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BONE MARROW PLASMACYTOSIS

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An increase in plasma cells (plasmacytes) in the bone marrow occurs most strikingly in multiple myeloma but also in a considerable number of other conditions including Hodgkin's disease, rheumatic fever, aplastic anaemia, etc.

The interpretation of this marrow plasmacytosis may present peculiar difficulties. In a number of conditions, particularly rheumatic fever, the plasmacytosis has been closely correlated with the changes in the gamma globulin. In other cases the problem may be whether the plasmacytosis can be held to support a diagnosis of multiple myeloma.

The problem is illustrated by four cases which were recently investigated at the Addington Hospital, Durban.

Case 1. J. M., a European male aged 64.

History. For the past three years the patient has complained of a dull pain of varying severity in the lumbar region. The pain is referred to the front of the abdomen and is aggravated by movement. At times it is so severe that he screams out with it.

About one year ago he noticed that he had become about two inches shorter in height. Four months ago his appetite became poor. He has lost about 15 lb. in weight.

Physical Examination. He appears pale and does not look well. There is a marked dorsal kyphosis; *Blood Pressure*, 160/100 mm. Hg.

Urine. A trace of albumin was present. The deposit showed a fair number of granular casts. Bence-Jones protein was absent.

Haematological Findings. The picture is that of a progressive anaemia. The following are the haemoglobin values over the last two years:

22 December 1949, 12.5 gm. %.
16 February 1950, 12.1 gm. %.
20 February 1951, 10.3 gm. %.
30 March 1951, 8.8 gm. %.

Further details are given in Table I.

The erythrocytes showed a marked tendency to autoagglutination which was seen as clumping of the cells in the oxalate tube and as a striking tendency to rouleaux formation in peripheral blood smears. Otherwise the red cells showed no obvious pathological changes.

Biochemical Findings (*Table II*). The significant finding is a marked elevation of the serum globulin

TABLE I: HAEMOTOLOGICAL FINDINGS

Name	*Case 1 (J. M.)*	*Case 2 (L. A.)*	*Case 3 (A. van S.)*	*Case 4 (J. F.)*
Haemoglobin gm. %	8·8	8·2	9·4	12·2
Red Cells (Millions/c.mm.)	2·68	2·35	3·08	3·75
P.C.V. %	28	27	31	37
M.C.V. (c./μ.)	105	113	100	100
M.C.H.C. %	31·5	30	30·5	31
White Cells (per c.mm.)	6,000	12,000	5,000	20,000
Polymorphs %	69	34	64	62
Lymphocytes %	25	58	30	14
Monocytes %	5	5	6	10
Eosinophils %	1	2	0	1
Plasma cells %	0	1	0	13
E.S.R. (Westergren) (mm. in first hour)	111	108	106	98

TABLE II: BIOCHEMICAL FINDINGS

Name	*Case 1 (J. M.)*	*Case 2 (L. A.)*	*Case 3 (A. van S.)*	*Case 4 (J. F.)*
Serum Proteins gm. %				
Albumin	2·50	4·70	3·40	3·50
Globulin	7·50	2·25	3·05	2·40
Total	10·00	6·95	6·45	6·45
Serum Calcium (mg. per 100 c.c.)	11·6	11·6	9·3	10·0
Inorganic Phosphorus (mg. per 100 c.c.)	2·5	3·9	3·9	3·3
Alkaline Phosphatase (K.-A. units)	5·75	9·85	9·6	6·0

(7.5 gm. %), the total serum proteins being 10 gm. %. Gastric analysis showed a histamine-fast achlorhydria.

Radiological Changes. There were multiple, well-defined translucent zones in the temporal, parietal and sphenoidal areas of the skull, and in the pelvic and iliac bones. The vertebral column shows an osteoporosis with wedge compression of D8 and D12. The chest is emphysematous.

Bone Marrow Findings. The marrow shows a striking infiltration by plasma cells, these constituting approximately 54% of the nucleated cells present. The great majority of these cells had the characters of mature plasma cells. Binucleate plasma cells were common and occasional plasmablasts were present. Further details in Table III.

Case 2. L. A., a European female aged 50.

History. For the past three days the patient has complained of diarrhoea, stools being macroscopically normal, and of globus hystericus. The patient has considerable financial worries and has been under the care of a psychiatrist for the last year.

Physical Examination. Completely negative. The *urine* showed a dense cloud of albumin. Bence-Jones protein was not detected.

Haematological Findings. The picture is that of an anaemia (haemoglobin, 8.2 gm. %) which is slightly macrocytic (M.C.V., 113 c. μ and M.C.D. 7.8 μ) (Table I).

The erythrocytes are normochromic with a fair degree of anisocytosis and poikilocytosis. Normoblasts (two per 100 white cells counted), myelocytes and promyelocytes were present in the peripheral smears. Thus the picture is that of a leuco-erythroblastic anaemia.

Biochemical Findings. These were essentially normal. Gastric analysis showed some free hydrochloric acid after histamine, but not after an alcohol test meal.

Radiological Changes. Spondylarthrosis of L4 and L5.

Bone Marrow Findings. Again the outstanding feature of this marrow was the high proportion of so-called plasma cells (over 20%) and also of reticulum cells (over 10%). Details are given in Table III. The preponderant cell was a large bizarre 'plasma cell' four to seven times the size of a red cell with a blue foamy cytoplasm, and a nucleus larger than that of the mature plasma cell, the chromatin showing a more open meshwork. Many were multinucleated, up to five nuclei being present. In some of the smears these cells were present in solid sheets.

TABLE III: BONE MARROW FINDINGS

Name	*Case 1 (J. M.)*	*Case 2 (L. A.)*	*Case 3 (A. van S.)*	*Case 4 (J. F.)*
Reticulum Cell ..	0	10·5	0	1·8
Myeloid Series				
Polymorphonuclear				
Neutrophil ..	9·0	30·5	32·2	29·4
Eosinophil ..	0·5	0·5	0·4	0·2
Metamyelocyte				
Neutrophil ..	13·0	8·0	17·0	18·0
Eosinophil ..	0·5	0	0	0
Myelocyte				
Neutrophil ..	7·5	1·5	13·4	22·0
Eosinophil ..	0·5	1·0	0·8	0·6
Promyelocyte ..	0	0	0·2	2·8
Myeloblast	0	0	0	0
Erythoid Series				
Proerythroblast ..	0	1·0	0	0·4
Normoblast				
Basophilic ..	0	1·5	0·8	0·2
Polychromic ..	8·0	11·0	11·6	7·6
Orthochromic ..	0	4·0	4·4	0·4
Lymphocyte ..	7·0	9·5	9·0	3·4
Plasma Cell ..	54·0	20·5	10·2	13·0
Megakaryocyte ..	0	0·5	0	0·2
Myeloid: Erythroid Ratio	3·9–1	2·6–1	4·2–1	9–1

Case 3. A. van S., a European female aged 73.

History. The patient gave a vague story of progressive weakness and tiredness for the past four months. With it there has been a loss of appetite and some loss of weight.

Physical Examination. She is a frail white-haired old lady. Blood pressure, 180/110 mm. Hg.

Urine. A faint cloud of albumin was present. Bence-Jones protein was not detected.

Haematological Findings. The picture is that of an anaemia (haemoglobin, 9.4 gm. %) with an M.C.V. that was consistently raised in repeated blood counts (Table I). The red cells were normochromic with a small degree of anisocytosis. Reticulocytes were 0.8% and there was no response to liver.

Biochemical Findings. There is a slight elevation of the serum globulin (Table II). Gastric analysis showed a histamine-fast achlorhydria.

Radiological Changes. The vertebral column is markedly osteoporotic with collapse of the body of D7. There are 'deposits' in the right lower ribs. There is a densely calcified abdominal aorta.

Bone Marrow Findings (Table III). Plasma cells exceeded 10% of the total nucleated cells in this marrow. They were all mature plasma cells.

Case 4. J. F., a European female aged 63.

History. She was admitted complaining of a dull pain of 10 days' duration in the left side of the chest.

Physical Examination. Pyrexial.

Chest. Crepitations at the left base.

Urine. A trace of albumin was present. Bence-Jones protein was not detected. There were fair numbers of pus cells in the deposit, and culture yielded *B. coli.*

Haematological Findings. The white count was 20,000 per c.mm. with 62% polymorphs and 13% plasma cells. Many of these plasma cells contained Russell bodies. Three days later the count had come down to 13,000 per c.mm. with 3% plasma cells, and a week later the count was 9,000 per c.mm., the plasma cells having disappeared. The red cells showed no obvious pathological changes.

Biochemical Findings. These were normal and gastric analysis showed a normal curve.

Radiological Changes. There was a segment of consolidation at the left base anteriorly. This area disappeared after a course of antibiotics. No skeletal abnormality was noted.

Bone Marrow Findings. The marrow showed 13% plasma cells. These were all mature plasma cells. As in Case 3, there were occasional binucleate cells and very occasional bizarre cells. In addition this marrow showed a well-marked myeloid hyperplasia.

DISCUSSION

There appears to be general unanimity that the percentage of plasma cells in a marrow from a normal subject is less

than 2.0%. A higher percentage of plasma cells, however, is often found in a host of apparently unrelated conditions.

Thus, of the marrow differential counts recorded by Leitner,[1] the percentage of plasma cells in 45 cases was between 2-4%, and in a further 22 cases it was between 4-6%. A further eight were above 6%. These were cases of polyarthritis (6%), aplastic anaemia (10.75%), measles (7.0%), essential thrombocytopenia (7.0%), Hodgkin's disease (7.0%), toxic jaundice (7.9%), acromegaly (7.0%) and rheumatoid arthritis (6.0%). With the exception of the cases of measles and Hodgkin's disease, no comment was made by the authors on these increases in plasma cells.

Fadem and McBirnie[2] record increased numbers of plasma cells in the marrow in another six cases. These are Hodgkin's disease (23.6%), lymphosarcoma (6.3%), acute monocytic leukaemia (6.7%), primary 'refractory' anaemia (6.2%), hiatal hernia (5.4%) and papilloma of the bladder (6.0%). In none of these cases was there any evidence of myelomatosis.

Good and Campbell,[3] in 15 cases of acute rheumatic fever, found the percentage of plasma cells to vary from 2.5-7.2%.

The distinction between the plasmacytosis of multiple myeloma and that of non-myelomatous conditions can be a very difficult one. It depends on:

1. Differences between the myeloma as opposed to the plasma cell.
2. The general clinical, laboratory and radiological features of the case.

Although there are undoubted differences between the typical myeloma cell and the plasma cell, these differences are not absolute and bizarre plasma cells are common in non-myelomatous conditions. Even more important is that the cells in a typical case of myeloma may be indistinguishable from ordinary plasma cells. The percentage of plasma cells in a reliable differential count is probably significant. Although Fadem and McBirnie record over 23% plasma cells in an apparently non-myelomatous condition, in general figures of that magnitude are highly suggestive of myelomatosis. Little significance can be attached to binucleated plasma cells and the occasional plasmablast since they are all seen in non-myelomatous conditions.

Thus, where the marrow findings are equivocal, such as in Cases 3 and 4, the associated features must be taken into account, particularly radiological changes, changes in the globulin fraction of the plasma proteins and the presence of Bence-Jones proteinuria.

Case 1 (J. M.) fulfils all the criteria for the diagnosis of multiple myelomatosis and is acceptable as a proved case. In spite of a textbook picture of the disease, he had been variously diagnosed as lumbago, carcinomatosis and, more latterly, as a parathyroid tumour for which an exploration of the neck was undertaken. The differentiation of the latter condition can be made by the inorganic phosphorus which is low in hyperparathyroidism, and the alkaline phosphatase which is raised in hyperparathyroidism. They are both normal in myelomatosis. Serum calcium may be raised in both conditions.

Case 2 (L. A.) presents with a leuco-erythroblastic anaemia and a marrow showing a high proportion of atypical plasma cells and reticulum cells.

The bone marrow is very strongly suggestive of myelomatosis and the cells in general have the characters of myeloma rather than plasma cells. The association of reticulum cells is interesting and has been noted in other cases of myelomatosis. It has been held to support the view that the reticulum cell is the immediate precursor of the plasma and myeloma cell and this view has been generally accepted.

The absence of radiological changes, and to a lesser extent of changes in the globulin fraction of the plasma, is perhaps disconcerting, but does not invalidate the diagnosis of myelomatosis.

Case 3 (A. van S.) presents a problem. A number of features favours a diagnosis of myelomatosis. These are:

1. Bone marrow findings (plasma cells, 10.2%).
2. Radiological changes (collapsed vertebra and rib deposits).
3. Anaemia and slightly raised serum globulin.

In view of these features, she was considered a probable case of myelomatosis. Aspiration of the rib deposit would be the obvious step to establish the diagnosis but it was not possible in this case.

Case 4 (J. F.) presented as a pneumonic consolidation which responded both clinically and radiologically to antibiotics. At the same time she was found to have 13% plasma cells in her peripheral blood as well as 13% plasma cells in the marrow. The blood plasmacytosis disappeared in a few days but a sternal marrow repeated two weeks later still showed over 7% plasma cells.

Plasma cells in the blood occur in some of the infectious fevers, notably rubella and measles, in so-called plasma cell leukaemia and uncommonly, but not unexpectedly, in myelomatosis. It has been suggested that the plasma cells play a part in the antibody response mechanism. Thus in acute rheumatic fever a definite and consistent increase of plasma cells in the marrow has been correlated with an increase in the gamma globulin. The suggestion is that the globulin is formed by the plasma cell and this is also the usual explanation of the hyperglobulinaemia of myelomatosis.

On the other hand, can one exclude myelomatosis in such a case? All that can be said is that apart from the plasmacytosis there is no evidence in favour of the diagnosis. However, as long as the plasmacytosis remains unexplained it must remain a possibility.

SUMMARY

Four cases showing plasma cells in the bone marrow varying from 10% to 54% are presented. Of these, one was a typical case, and two others probable cases of multiple myeloma.

The problem of increased numbers of plasma cells in the marrow in non-myelomatous conditions is discussed.

REFERENCES

1. Leitner, S. J. (1949): *Bone Marrow Biopsy*. London: J. and A. Churchill.
2. Fadem, R. S. and McBirnie, J. E. (1950): Blood, **5**, 191.
3. Good, R. A. and Campbell, B. (1950): Amer. J. Med., **9**, 330.

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VAN DIE REDAKSIE

'N INTERNASIONALE SENTRUM VIR STATISTIEK

Skikkings is tans voltooi vir die daarstelling van 'n WGO sentrum vir probleme, voortspruitende uit die toepassing van die *Internasionale Statistiese Rangskikking van Siektes, Beserings, en Oorsake van Dood.* Die oprigting van so 'n sentrum was aanbeveel deur die Komitee van Eksperte op Gesondheidstatistieke [1] en is goedgekeur deur die Derde Vergadering vir Wêreldgesondheid.[2] Dit sal wees by die Algemene Registrasiekantoor, Londen, en sal bestuur word deur dr. P. Stocks, wat sy pos as Hoof Mediese Statistikus afgelê het om hierdie werk te aanvaar.

Die vernaamste werksaamhede van hierdie sentrum mag voorlopig onder sewe hoofde gegroepeer word:

1. Die bestudering van kodemoeilikhede soos ondervind in nasionale kantore, waar sulke moeilikhede ontstaan as gevolg van:

(a) Foute en gebreke in die *Klassifikasie* self;

(b) Gebrek aan sekuurheid van die maatstaf wat aangewend word by die keuse van die grondoorsake van dood;

(c) Verskille in die samestelling en gebruik van die mediese sertifikaat vir die oorsaak van dood;

(d) Afwesigheid van reëls vir die hantering van veelsoortige siektesomstandighede.

2. Samesprekings met die nasionale kantore wat die *Klassifikasie* gebruik, om so spoedig moontlik die moeilikhede hierbo aangegee op te los, deur besluite uit te vaardig, oor kleinere puntjies en eenstemmigheid te bereik omtrent voorlopige oplossings oor belangrike sake; hierdie besluite bly dan onderhewig aan latere bevestiging deur die Komitee van Eksperte op Gesondheidstatistiek, of 'n subkomitee daarvan.

3. Die bestudering van die vergelykbaarheid van die nuwe *Klassifikasie* met die vyfde Hersiening, soos uitkom in die sterftestatistiek, wat deur-beide lyste gekodifiseer word, sonder verandering van sertifikaat of van die wyse van seleksie, m.d.o. op die daarstelling van 'n rapport om lande te help met moeilikhede wat hulle ondervind om die nuwere statistieke aanknoping te laat kry by dié van voorgaande jare.

4. Die bestudering van die gebruik, wat daar gemaak word deur een of meer lande, van die Internasionale Sertifikaat oor die Oorsaak van Dood, met besondere referte tot die teboekstelling van veelsoortige oorsake, die tydsverloop tussen die beweerde aanvang van siekte en intrede van dood, ens., in die hospitaal-, plattelandse en stedelike praktyk, sodat 'n verslag opgestel kan word vir versending na ander lande en vir voorlegging aan die Komitee van Eksperte op Gesondheidstatistiek.

5. Die bestudering van die verskillende bekorte lyste wat in gebruik kom vir allerlei doel, vernaamlik dié vir hospitaalstatistieke, as ook van die ondervinding wat opgedoen word deur middel van hulle, om sodoende in staat te wees om raad te gee i.v.m. die bruikbaarste bekortings

1. Chron. World Hlth. Org., 1949, **3**, 247.
2. Chron. World Hlth. Org., 1950, **4**, 237.

EDITORIAL

AN INTERNATIONAL STATISTICAL CENTRE

Arrangements have now been concluded for the establishment of a WHO centre for problems arising in the application of the *International Statistical Classification of Diseases, Injuries, and Causes of Death.* The establishment of such a centre was recommended by the Expert Committee on Health Statistics [1] and was approved by the Third World Health Assembly.[2] It will be located at the General Register Office, London, and will be directed by Dr. P. Stocks, who has retired from the post of Chief Medical Statistician to undertake this work.

The principal activities of the centre may, for the present, be grouped under seven headings:—

1. Study of coding difficulties experienced by national offices, such difficulties arising from:

(a) Errors and faults in the *Classification* itself;

(b) Lack of precision in the rules for selecting the underlying cause of death;

(c) Variations in the form and use of the medical certificate of cause of death;

(d) Absence of rules for dealing with multiple conditions in morbidity.

2. Discussion with national offices using the *Classification* in order to resolve as quickly as possible the difficulties listed above, by giving decisions on minor points and reaching agreement on tentative solutions of more important matters, these solutions being subject to subsequent confirmation by the Expert Committee on Health Statistics or by a sub-committee.

3. Study of comparability of the new *Classification* with the fifth Revision, as shown by statistics of deaths coded by both lists without change of certificate or rules of selection, with a view to producing a report to help countries in their difficulties in linking the new statistics to those of past years.

4. Study of the use being made, in one or more countries, of the International Certificate of Cause of Death, with special reference to entry of multiple causes, interval between reputed onset of disease and death, etc., in hospital, rural and urban practice, so that a report can be drawn up for sending to other countries and for submission to the Expert Committee on Health Statistics.

5. Study of the various condensed lists coming into use for all kinds of purposes, particularly hospital statistics, and of the experience gained with them, so as to advise

1. Chron. World Hlth. Org., 1949, **3**, 247.
2. Chron. World Hlth. Org., 1950, **4**, 237.

en om al te grote verskeidenheid by hierdie aanvullende lyste te probeer vermy.

6. Die bestudering van die voortbrengsele, wat deur middel van spesiale onderverdelings van klasse in die uitvoerige lys vir nasionale doeleindes gemaak word, as ook deur spesialiteit-organisasies, met die doel om onnodige verskeidenheid te voorkom sowel as om ondervinding op te doen oor die aanwending van sulke voortbrengsele.

7. Die bestudering van die vooruitgang van navorsingskemas, wat die gebruik van die *Klassifikasie* raak en aanbeveel is deur die Komitee van Eksperte op Gesondheidstatistieke en sy onderkomitees.

Briefwisseling met dr. Stocks moet gerig word aan: *WHO Centre for Problems Arising in the International Classification of Disease, General Register Office, Somerset House, London, W.C.2, England.*

on the most useful condensations and to try to avoid too much diversity in these supplementary lists.

6. Study of the elaborations by special subdivisions of categories in the detailed list which are being made for national purposes and by specialist organizations, with a view to avoiding unnecessary diversity and collecting experience on the use of such elaborations.

7. Study of progress of research projects involving the use of the *Classification* which have been recommended by the Expert Committee on Health Statistics and by its sub-committees.

Correspondence to Dr. Stocks should be addressed to: WHO Centre for Problems Arising in the International Classification of Disease, General Register Office, Somerset House, London, W.C.2, England.

STUDIES ON PAIN

II: POST-TRAUMATIC PAIN

FROM OBSERVATIONS ON 93 CASES

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(*Concluded from p. 587*)

PAIN INITIATED BY THERAPEUTIC PROCEDURES

It is distressing but only too true that trauma inflicted by certain therapeutic procedures, even in the absence of obvious complications, may itself be the starting point of a disabling painful state. The knife of the surgeon, the forceps of the dentist are as potent sources of such a state as the bullet of an enemy! The formidable list of 37 such instances encountered in the present study is summarized in Table V.

TABLE V: THERAPEUTIC PROCEDURES INDUCING A SEVERE PAINFUL SYNDROME

Procedure	*Personal Cases*	*Cases from Neurosurgical Service, Johannesburg*	*Total Cases*
Dental Extraction	1	8	9
Amputation	8*	2	10
Enucleation of eye	—	1	1
Drainage of frontal sinus	—	1	1
Excision of simple tumour	1	1	2
Intravenous infusion, cut down	1*	—	1
Transplantation of ulnar nerve	1	—	1
Removal of prolapsed intervertebral disc	1*	1	2
Chordotomy	1*	—	1
Operation for spondylolisthesis	1	—	—
Nephropexy	1	1	2
Nephrectomy	—	1	1
Sympathectomy	3*	—	3
Repeated lumbar punctures	—	1	1
Broken lumbar puncture needle	—	1	1
Injection into sciatic nerve	—	1	1
Inguinal herniorrhaphy	1	—	1
Total:	20	19	38

(* More than one procedure in a case)

In the present series, cases of facial pain following legitimate dental practice have been particularly significant. Instances of trigeminal neuralgia wrongly treated by dental extraction have been rigidly excluded from the present discussions. Nine such cases were encountered, two examples are detailed below:

Case 49K. Rabbi, *aet.* 31 years. Total dental clearance for pyorrhoea 4½ years before first examination. About six weeks later, when gums almost healed, dull nagging pain commenced on right side of upper jaw. Later, severe lancinating pains punctuated the persistent pain, and occurred in the same region. There were 5-6 such exacerbations daily. Pain interfered with sleep and ability to concentrate. An operation was performed on the right maxillary antrum, on at least doubtful indications, one year later, with relief from pain for six months. A second operation on the antrum then brought no relief. Several anaesthetic injections were given into the gum from time to time, each giving short-lived relief. Eight months before examination alcohol injection into gum had given relief for a few weeks. Five weeks before examination some unspecified operation on the gum had given relief for two weeks.

On examination: a thin, pale, suffering man, who felt that life was not worth living; tenderness right upper jaw in region of molars and premolars; no sensory anomalies in distribution of trigeminal nerve; otherwise examination negative.

Diagnosed as 'traumatic neuritis of second division of trigeminal nerve'. In November 1942, the second division of trigeminal nerve was sectioned in front of the ganglion. No real, lasting relief. Pain persisted. In 1945 patient went to U.S.A. and visited Dr. Mixter's clinic. Operation was not performed here but at another clinic retrogasserian root section was carried out. This was soon followed by excruciating pains in the right orbit and eye, despite

complete and lasting insensibility of the cornea. A letter from the patient's doctor, dated 5 June 1947, tells of continuation of this, and states that retrobulbar injections of high doses of Novocain had no influence on the pain.

Case 43. Mrs. B.S. *aet.* 52 years. One year before first examination had right canine and two premolars removed. Within the ensuing month experienced severe pain in the inner angle of the right eye, of constant burning type. Advised to have all her teeth out but thereupon consulted several dental surgeons and saved her teeth. An ophthalmic surgeon found no defect in his sphere. After six months of suffering, an aural surgeon performed an antrostomy. Just prior to this, she had started to complain of constant burning pain in the gum of the right upper jaw where the teeth had been extracted. Several intranasal procedures followed and achieved nothing but to add head pains to those previously felt in the face. A surgeon carried out anaesthetic infiltrations of the stellate ganglion with no effect. Pain continues unabated to time last seen, four years after its onset.

A few other examples of operative-induced painful state follow:

Case 60K. Male *aet.* 45 years. Continuous pain related to scar of frontal sinus operation—scar excised six months later—relief for only a few days—severe aching over upper half of eyebrow—at examination six months after excision of first scar: touching of area round scar caused intense, stabbing pain which spreads in field of first trigeminal division.

Case 61K. Male *aet.* 26 years. Tender lump had been removed from 12th rib. Free from pain for six months, then stabs of pain, 2-3 per week. Two-and-a-half years before examination pain developed girdle character, starting in right lower quadrant of abdomen and going up obliquely to the costal margin—lancinating for 5-10 minutes and then passing off. Eased by pressure or taking deep breaths. Two to three spasms per week, or several times a day. On occasions pain doubled patient up and caused him to drop to the ground. For one year prior to examination pain radiated right round to the front of the trunk, and patient experienced an empty, hollow feeling when pain came on.

Examination: tender over vertebrae L 1-2; old scar: pressure over scar produces instantaneous pain in every way like spontaneous pain; pressure in right lower quadrant of abdomen produced tenderness. Diagnosed: 'pressure neuritis' of last dorsal nerve.

Case 93K. Miss E.M. Severe pain in both lower limbs, which had been paralysed ever since an operation for herniated nucleus pulposus, performed in another country. On 13 April 1943, chordotomy by Mr. Krynauw for intense and persisting pain. The operation was done on both sides at T 1-2 level.

The pain in legs and abdomen were relieved by operation, but severe, bilateral root pains developed at the neurological level of the operation. This continued to give trouble for several months.

AMPUTATION AND PAIN

Experience with some 150 British soldiers with major limb amputations gave the impression that severe, prolonged, intractable post-amputation pain is rare. Only two cases were seen. Most pains encountered in the group were rather transient affairs due to very obvious causes, among which sepsis in the stump and tightness of the flaps accounted for most cases.

The illusion of the phantom is almost universal but it is seldom painful. Henderson and Smyth (1948) have described the features of the 'natural phantom' in great detail from a study of some 300 amputees. Its behaviour and evolution 'is as if the related cerebral centres were for a time in a state of heightened activity, the later subsidence of which results in telescoping of the phantom and its eventually fading . . . superadded sensations sometimes appear which are peculiar to the patient and are believed to be psychogenetically determined from the highest cerebral level. They may be mild, representing incidents in the patient's past experience, or, rarely, disagreeable severe spontaneous pain, distorted attitudes, and involuntary spasmodic movements dominating the phantom. The continuation in the phantom of pre-amputation pain or posture seems to be determined in many instances at least, by its psychological importance and not by its severity or duration.'

The contention as to the cause of the painful phantom is an old one, figures like Descartes and Weir Mitchell have entered the lists. Some have stressed the role of a disturbed body image, others have given precedence to the bombardment of the sensorium by continued impulses from the periphery. Whatever the truth may be, there is no doubt that one can recognize two groupings of pain in amputees, first that referred to the stump or more proximally, second, that which is referred to the phantom (Table VI).

TABLE VI: DISTRIBUTION OF PAIN ASSOCIATED WITH AMPUTATION

Case No.	*Site of Amputation*	*Pain in Phantom*	*Pain in Retained Parts*
14	Through metacarpals (for trauma)	+	+
16	Lower third forearm (for trauma)	+	—
18	Fingers (for trauma)	—	+
23	Finger (for trauma)	—	+
32	Below knee (for trauma)	—	+
37	Upper end humerus (for trauma)	+	+
44	Below knee (for trauma)	+	—
57K	(1) Below knee (for trauma) (2) Above knee (for pain)	+ +	+ +
58K	(1) Interphalangeal (for infection) (2) Metacarpal (for pain)	— —	+ +
48	(1) Below elbow (for trauma) (2) Above elbow (for trauma)	+ +	+ +

Again, it is obvious that the distal distribution of pain in some instances, without loss of a part of the limb, is not unlike that in a phantom part.

TRANSFERENCE OF PAIN AFTER SURGICAL TREATMENT

Case 44. This old lady was a domestic attendant on the staff of a hospital. Two years before operation she had a fibro lipoma removed from the left side of the lower abdominal wall. Perfect, uncomplicated healing followed,

but pain developed around the scar. This became severe and constant and occupied her whole attention. In 1947, a right upper dorsal spino-thalamic tractotomy was performed. The pain on the left side disappeared forthwith but from the first post-operative day its exact mirror-image appeared on the opposite side of the abdomen and persisted to the time last seen, one year later, July 1948.

TIME OF ONSET OF PERSISTING POST-TRAUMATIC PAIN

The agonizing distress that is in some cases to dominate the whole being of the subject, varies considerably in the time of its commencement in relation to the infliction of injury. It may appear from the moment of injury, as in Case 1, it may be well-established within a few days:

Case 33. American soldier wounded at Salerno on 18 September 1943—penetrating wound in region of 7th cervical vertebra—left posterior, with two lodging metallic bodies—one removed during wound toilet on 19 September 1943.

Seen at 106 (S.A.) General Hospital, in Tripoli, on 22 September 1943. The man complained of severe, diffuse pain in the left upper limb and left side of the chest; intense hyperaesthesia and hyperalgesia over the same area; left upper limb dripping sweat and burning hot. X-rays showed a metallic foreign body lying close to the region of the 6th and 7th cervical nerve roots.

Stellate block via anterior route on account of a septic posterior wound, produced relief for a few hours.

Evacuated to Algiers a few days later.

It may arise as a summation of sensory stimuli after a period of weeks or months and be precipitated by one particular stimulus, as in Case 2, or it may first appear years after the original trauma, as in Case 9.

THE PSYCHOLOGICAL COMPONENT

Three things seem self-evident: Certain persons are likely to develop persistent pain after injury, in others prolonged suffering from various causes may bring about a similar tendency, the two factors may operate in any particular instance. There is yet a fourth consideration that bears mentioning: the prolonged obession with pain may almost constitute the *raison d'être* in some cases. This is suggested in the following case:—

Case 37. A lady of 70 years had sustained a traumatic amputation of the left arm, followed by formal surgical amputation just below the shoulder, ten years before. She thereafter experienced severe, continuous pain. Many forms of treatment gave short-lived relief. Pain continued and increasingly large amounts of analgesic drugs became necessary for its relief. In January 1946 I injected Novocain round the brachial plexus. This gave some relief for a week. She came to the Neurosurgical Service on several occasions thereafter. In November 1947 a prefrontal leucotomy was contemplated, but before arrangements could be made for her admission she developed a severe bout of gastro-enteritis. She was admitted to the medical service, and during her stay there required far greater doses of analgesics than before. Toward the end of her stay in hospital her husband died. The news was kept from her and in due course she left hospital. We sent for her in January 1948, but found that her pain had gone. She was gaily dressed, whereas we had never seen her other than in the drabbest of outfits!

The effect of this shock (or relief) therapy lasted only a few weeks, and she was back, jealously guarding her stump. Mesencephalic tractotomy was performed. The pain disappeared but so did her interest in life, despite good post-operative recovery.

Six months after discharge from hospital she died from unrelated cause—a sudden cerebro-vascular accident. Pain had not returned, nor had interest in her former social contacts and interests. Perhaps she had ceased to be a centre of attraction to her little circle of cronies.

GENERAL COMMENTS

Tissue injury, as shown by the work of Lewis and his co-workers (previously reviewed), produces immediate and delayed pain, the latter associated with local vascular changes, probably in the main at least in response to changes in local metabolism. This effect, however, is short-lived in the absence of complications and the type of pain here considered represents an unusual response to injury. It is essential that this be appreciated.

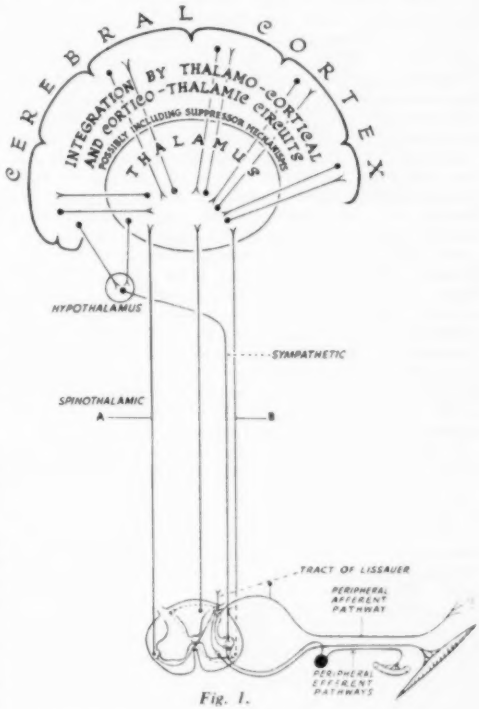

Fig. 1.

An earlier communication (1948) reviewed observations and views on pain in general. It is fruitless to repeat the references used in that paper. Certain suggestions were put forward concerning neural mechanisms involved. These can be schematically represented as in Fig. 1.

From a point of injury (the stippled area in the figure) impulses reach the spinal cord via posterior nerve root fibres. Fibres subserving pain are traditionally held to ascend in the contra-lateral spinothalamic tract (A), after preliminary oblique crossing. Wolff (1948) postulates also a double-crossing of some fibres and ascent of impulses in the ipsilateral spinothalamic tract (B).

Through intercalated neurons, or the so-called internuncial neurons, impulses may overflow into efferent pathways at cord levels. As in the case of epilepsy (1949), the occupation of motor or sensory pathways with such impulses may militate against their activation in the normal manner, producing reflex paralysis and sensory disturbances. Such an effect is rather rare and the more usual cause of apparent motor disability in the cases under review appears to arise from pain aggravation.

Similarly, efferent impulses may excite or impair conduction along fibres of sympathetic outflow, with subsequent vasoconstriction and vasodilatation. Vasodilatation may be produced via peripheral pathways still not finally known but much speculated upon. In general, these effects are much more commonly seen in the earlier months of post-traumatic pain, but are even then not constant.

The motor and vasomotor effects are thus secondary phenomena. When present they may aggravate the pain-suffering, but this is not always so. Certainly, vasospasm is not always attended by pain.

Similarly, as Wolff has stressed, muscular effects may also introduce new sources of pain. In these ways the area of pain may grow, but in this extension the involvement of other cord segments via Lissauer's tract and internuncial neurons probably play a significant part.

The interpretation of pain must depend on integrations between thalamus and cerebral cortex. In these circuits there may well be suppressor mechanisms that could account for chronological, cultural, and individual variations in pain suffering and its so-called affective component. The only direct evidence to support such a contention comes from the effects of various forms of surgical treatment, which are being considered separately (1951). Continued suffering may throw the suppressor mechanisms out of gear and lower resistance to pain.

It also seems possible that autonomic impulses may excite peripheral nerve endings, setting up a cycle from which impulses once again reach the thalamo-cortical circuits. Such activation may arise in spinal segments alone, or through the autonomic outflow attributed to the hypothalamus.

It seems likely that a number of circuits may be responsible for the unusual perpetuation of pain. Activity in these may be initiated from areas of excessive discharge and, as in the case of epilepsy, secondary discharging foci may develop at other levels within the nervous system.

SUMMARY AND CONCLUSIONS

A series of cases of unusual post-traumatic pain response is reviewed.

Injury to a recognized nerve or nerve root is a common, but not invariable, cause of such a state, which may be brought about by trivial or severe injury.

Motor, sensory and vasomotor effects may arise as secondary phenomena. These are all inconstant and vasomotor effects tend to become less striking in time.

There is a tendency to over-reaction to freshly applied painful lesions, even when made at new levels.

Therapeutic procedures are a common source of the disorder under discussion.

Prolonged pain suffering and complaint can become an important part of the psychological make-up.

In seeking a solution to some of the problems of these distressing cases, activity within neural circuits should be stressed rather than the role of isolated conducting pathways.

An analogy can be drawn with the primary and secondary discharging foci of epilepsy.

Part of the work leading to this paper was undertaken while holding a South African Council for Scientific and Industrial Research Scholarship.

REFERENCES

Beecher, H. K. (1946): Ann. Surg., **123**, 96.
Erasmus, J. F. P. (1946): Thesis for the degree of M.D. (Rand.).
Erasmus, J. F. P (1947): S. Afr. Med. J., **21**, 806.
Erasmus, J. F. P. (1948): *Ibid.*, **22**, 683.
Erasmus, J. F. P. (1949): *Ibid.*, **23**, 740; 892; 977.
Erasmus J. F. P. (1951): In the press.
Henderson, W. R. and Smyth, G. E. (1948): J. Neurol. Neurosurg. Psychiat., **11**, 113.
Wolff (1948): *Headache and Other Head Pain.* Oxford University Press.

THE FAMILY DOCTOR*

By The S.A.B.C. Radio Doctor

'I swear by Apollo, the physician, and Aesculapius and Hygeia and Panacea and all the gods and all the goddesses . . . that I will keep the sick from harm and wrong. To none will I give a deadly drug even if solicited, nor offer counsel to such an end . . . guiltless and hallowed will I keep my life and my art. I will cut no one . . . But will give way to those who work at this practice. Into whatsoever house I shall enter, I will go for the benefit of the sick, holding aloof from all voluntary wrong and corruption . . . Whatsoever in my practice . . . I shall see or hear amid the lives of men I will not divulge . . .'

* Report of a broadcast talk.

So runs part of the Oath of Hippocrates, which medical students take when they graduate and become doctors. The physician belongs to a profession dedicated to the good of mankind. He aims to prevent disease, to relieve pain and to heal the sick. To achieve this he must understand human nature and all the strange tricks it plays. The modern doctor is better trained and better equipped than he was 25 years ago. Disease is more thoroughly understood, more carefully studied and more skilfully treated than ever before. Human suffering has been reduced in a way to make the angels sing. Synthetic

substances can cure or control many of the diseases caused by parasites and bacteria. Old secrets of nutrition have been solved and new vitamins have been discovered. Laboratory tests have been devised to measure the efficiency of most organs of the body and X-rays enable us to peer into every nook and cranny. Diseases familiar to past generations have disappeared, and the death rate from others is falling rapidly. Public Health measures have lessened the sorrows and lengthened the lives of millions. To such good purpose has medicine advanced, that to-day the man of 40 can expect to live to 71 and the woman of 40 to 75.

With this greater expectation of life, new problems have arisen. Our population now abounds with sprightly youths of 65 and, whereas at the turn of the century, less than 50 persons in every 1,000 reached that age group, their number is now doubled. Old age does not necessarily mean ill health, but as more persons live longer, there is greater opportuni'y for chronic illness.

The recent advances in medical knowledge have not only changed the face of disease, but they have modified the practice of medicine. In this industrial age, in this era of specialization, of knowing more and more about less and less, the family doctor is fast going out of fashion, especially in the large cities. Medical specialization has divided the human body into many parts and, where so many specialists guard so many pieces, who will look after the whole? The old family doctor knew his patients and understood their ailments. In his role as confidant and confessor, busy but patient, he knew their social and economic difficulties. Through long and intimate association, he learned of the skeleton in every cupboard, and of the prodigals who had not returned. He encouraged the intelligent and sympathized with the weak. The furniture in his office was conspicuous by its absence, and his unused desk was littered with books, blotting paper and bottles. Most of his work lay in the home. The consulting room, after all, is an artificial environment, and almost invariably the patient is not his natural self. Knowledge of the day-to-day behaviour of an individual is best gained through close contact in his natural surroundings. There is no technique or apparatus to make certain that the patient is telling the truth, but the family doctor usually had his own little Scotland Yard. His study of the patient's temperament, and his contact with relatives and friends, gave him the clues he required. The old family doctor spent his whole life in one community and cared for his flock through several generations. Because he was no rolling stone, he knew when a mother's persistent headaches were due to a wayward daughter rather than to organic disease. He knew which of his families were emotionally unstable and liable to nervous breakdowns. He knew in which of them there had been cancer, diabetes or tuberculosis. He knew of their childhood diseases and past illnesses and was fully aware of their alcohol and tobacco habits. He understood their frailties, their stubbornness, their ignorance and their fears. His general practice provided him with the best training for psychology. Psychological illness, roughly speaking, is a matter of human beings in distress. Many of the cures worked by quacks who practice suggestion are achieved in those who are psychologically sick. As a guide, philosopher and friend, it was easy for the doctor to be the family psychologist. Always present at the birth of her children, he gained the mother's confidence and received her affectionate regard. The esteem in which a doctor is held by the woman he has confined is an important factor in treating the rest of her family. Every child specialist admits that the treatment of the nervous child begins with the education of the mother; but it is the family doctor who does the teaching. Sentiment may seem trivial, but it makes the world go round. Do away with it, life becomes an empty dream and the doctor a mechanical robot.

In this age of specialization the family doctor is unhonoured and unsung, but he is still the backbone of medicine. The personal and professional qualities expected of a general practitioner are no less than those required of a specialist. All doctors must undergo a most exacting discipline and all have to master a veritable encyclopaedia of facts and theories into the bargain. If a man's virtue is to be measured by his attitude towards suffering, then the doctor must surely head the list, for he makes the relief of suffering his life's work.

Even so-called 'General Practice' is in reality a special branch of medical work. Modern discoveries have put into the hands of the family doctor a wide range of diagnostic techniques and a whole armoury of powerful drugs. To be able to employ these to the best advantage calls for high qualities and great resourcefulness. Patients who would previously have been hospitalized, can nowadays be treated with equal success in the home, and this is where the family doctor comes in. After all, the majority of day-to-day ailments are simple and straight-forward, and do not require specialized skill. The practice of modern medicine has become a highly complex affair, but medical education has moved with the times and the family doctor of to-day is more competent than ever. The volume of medical knowledge is so vast, and increases so rapidly, that no one doctor can hope to absorb all he might like to. It is difficult enough for the specialist; it is still more so in general practice. When in doubt, therefore, the alert family doctor will not hesitate to refer his patient to a specialist or to a consultant. They, in turn, value his wisdom, and from him they learn things which are outside their own experience. The observations of the family doctor, in the home, are of great help to the consultant at the bedside.

Under the strains and stresses of modern life no family should be without its doctor. The medical profession to-day is as much concerned with the prevention of disease as with its cure. It is the family doctor who will vaccinate your child against smallpox and inoculate him against diphtheria. It is the family doctor, with his little black bag, who will answer your call in the dead of night. He is the first to hear of any epidemics, and leaves his telephone number whenever he goes out. It is he who will keep vigil at the bedside of your sick infant, or in the labour ward of a nursing home. It is your family doctor who will tell you if your 'migraine' is really due to 'one over the eight', and your imaginary heart attack to an accumulation of wind in the stomach. His timely intervention will prevent the rupture of an appendix or the coma of diabetes. Remember . . .

'To guard is better than to heal,
The shield is better than the spear.'

Our daily lives are surrounded by alarms and excursions enough, yet we invent our own fears. Alice in Wonderland's poor governess was frightened by her suggestion: 'Let us pretend that I am a hungry hyena and you are a bone'. We are frightened by anxieties even more absurd. In the psychological approach to patients, the family doctor has advantages not possessed by the specialist. It is he only who sees the patient with 'the hair down', as it were. Tests and laboratory studies, invaluable as they may be, can never replace intelligent observation of the patient himself. Michelangelo said: 'It is trifles which make perfection, and perfection is no trifle.' So it may be said of the minor details which go to make the perfect artistry of the good family doctor. General practice offers rich experience of human nature and great opportunity for satisfactory achievement. The family doctor has often been portrayed in painting, in fiction and even in Hollywood. One of the best tributes paid to him was Robert Louis Stevenson's:

'There are men and classes of men that stand above the common herd: the soldier, the sailor, the shepherd not infrequently; the artist rarely, the physician almost as a rule . . . Generosity he has, such as is possible to those who practice an art, never to those who drive a trade; discretion tested by a hundred secrets; tact tried in a thousand embarrassments . . . So it is that he brings air and cheer into the sick room, and often enough, though not as often as he wishes, brings healing.'

NEW PREPARATIONS AND APPLIANCES

RESINAT

Description. A yellow tasteless powder being chemically a polyethylene polyamine methylene substituted synthetic resin of the ion-exchange type. Presented in capsule form for convenient handling by the ambulatory patient.

Indications. In the treatment of peptic ulcer and other conditions attended by excess gastric acid and peptic activity followed by one or more of several sequelae.

Action. The activity of Resinat is the result of its ability to exchange positively or negatively without participating in the chemical reaction itself or without undergoing any change. It attracts the excess hydrochloric acid of the stomach and thus 'bonded' it may be said to accompany the excess acid into the intestine where, in alkaline environment, Resinat loses affinity for the acid molecules which are then discarded and become absorbed in a relatively harmless manner while the resin is eliminated unchanged and without exerting any effect whatever on the gastro-intestinal physiology.

Clinically, Resinat provides a nearly ideal answer to the problem of an antacid.[1-6] It is insoluble, non-irritating and well tolerated with no known toxic or other undesirable effects.[7] It has no constipating effect[5] and does not disturb the acid-base balance of body fluids. Resinat, by covering the eroded area with an inert substance, gives mechanical as well as chemical protection. It is not absorbed into system circulation and does not alkalinize the urinary tract.[6]

Dosage. In ordinary hyperacidity one or two capsules with a few sips of water usually produce prompt and sustained relief. The dose may be repeated as required. In acute peptic ulcer, patients are given one or two capsules every two hours during the day. Quantities as great as 102 gm. have been given with good effect and without side reactions, in a 24-hour period.

As in other forms of treatment, the necessary dietary restrictions should be enforced.

How Supplied. In gelatin capsules of 0.25 gm. each. Bottles of 50 and 100. An original product of the National Drug Company, Philadelphia, U.S.A. Literature and samples available on request from the sole South African distributors, The Pharmapak Co. (Pty.) Ltd., P.O. Box 7553, Johannesburg.

REFERENCES

1. Segal, H. L., Hodge, H., Watson, J. S., and Scott, W. K. (1945): Gastroenterology, **4**, 484.
2. Martin, G. J. and Wilkinson, J. (1946): Gastroenterology, **6**, 315.
3. Martin, G. J. and Wilkinson, J. (1946): Arch. Biochem., **10**, 205.
4. Segal, H. L. *et al.* (1947): Gastroenterology, **8**, 199.
5. Spears, M. M. and Pfeiffer, M. C. J. (1947): Gastroenterology, **8**, 191.
6. Kraemer, M. and Lehman, D. J. Jr. (1947): Gastroenterology, **8**, 202.
7. Kraemer, M. and Siegel, L. H. (1947): Proceedings of 100th Meeting of the Amer. Med. Assoc., Atlantic City, 13 June.

VERENIGINGSNUUS : ASSOCIATION NEWS

MINUTES OF A MEETING OF THE FEDERAL COUNCIL OF THE MEDICAL ASSOCIATION OF SOUTH AFRICA, HELD AT MEDICAL HOUSE, ESSELEN STREET, JOHANNESBURG, ON 12, 13 AND 14 APRIL 1951

Present:—*Border Branch*: Dr. R. Schaffer, Dr. P. F. H. Wagner.
Cape Eastern Branch: Dr. E. M. Britten.
Cape Western Branch: Dr. J. P. de Villiers, Dr. J. C. Gie, Dr. A. I. Goldberg, Mr. L. B. Goldschmidt, Dr. T. Shadick Higgins, Dr. R. L. Retief, Dr. A. W. S. Sichel.
East Rand Branch: Dr. E. Meltzer, Dr. E. W. Turton.
Griqualand West Branch: Dr. J. P. Collins.
Natal Coastal Branch: Dr. A. Broomberg, Dr. E. W. S. Deale, Dr. H. Grant-Whyte, Mr. A. G. Sweetapple.
Natal Inland Branch: Dr. S. Disler.
Northern Transvaal Branch: Dr. C. M. Grundlingh, Dr. J. H. Struthers, Dr. J. H. Sypkens, Mr. C. G. L. van Dyk.
O.F.S. and Basutoland Branch: Dr. D. Serfontein, Dr. R. Theron.
Southern Transvaal Branch: Dr. J. A. Bell, Dr. J. Black, Dr. Alice Cox, Dr. R. Geerling, Dr. C. A. H. Green, Dr. Maurice Shapiro, Dr. A. van der Poel, Dr. C. G. S. van Heyningen, Dr. L. O. Vercueil.
Transkei Branch: Dr. J. D. Joubert.
Ex Officio: Dr. J. H. Harvey Pirie, *Immediate Past-President*; Dr. J. S. du Toit, *Honorary Treasurer*.
In Attendance: Dr. A. H. Tonkin, Medical Secretary.
The Editor, Dr. H. A. Shapiro, was also present.

THURSDAY, 12 APRIL

The President, Dr. A. W. S. Sichel, declared the Meeting open at 9.30 a.m.

1. *Notice Convening the Meeting*, which had been published in the *Journal* of 3 March 1951, was taken as read.

2. *Proxies*: The Medical Secretary read the following Proxies which had been handed in:—
Dr. R. L. Retief *to act for* Dr. H. S. Gear.
Mr. L. B. Goldschmidt *to act for* Prof. J. F. Brock.
Dr. Alice Cox *to act for* Dr. T. Schneider.

3. *Apologies for Absence* were received from Prof. J. F. Brock, Dr. P. Connan, Dr. P. Jabkovitz and Dr. J. G. M. Richter.

4. *Welcome to New Members*: Dr. J. P. de Villiers introduced Dr. R. L. Retief who was acting for Dr. Gear during the latter's absence overseas. Dr. Harvey Pirie introduced Dr. A. van der Poel who had been appointed to fill the vacancy caused by the resignation of Dr. A. C. Schulenburg. They were welcomed by the President.

5. *Condolence*: The President referred to the loss which the Association and the Federal Council had sustained in the death of Dr. C. J. Albertyn. He paid tribute to the memory of Dr. Albertyn, and the Council rose as a mark of respect to his memory.

6. *Minutes* of the Meeting held in Johannesburg on 12, 13 and 14 October 1950, were *confirmed* and *signed*.

MATTERS ARISING OUT OF THE MINUTES

7. *International Vaccination Certificates*: Correspondence was submitted which had appeared in the *Journal* of 10 February 1951, and the Medical Secretary gave a brief résumé. *Noted*.

8. *Signing of Death Certificates by Interns*: The President reported that the whole position had been rectified by the passing of a further amendment to the Medical, Dental and Pharmacy Act and that interns were now permitted to carry out all the functions of a medical practitioner. *Noted*.

9. *Ethical Rule Concerning Benefit Societies*: A letter from the Southern Transvaal Branch was submitted, in which it was suggested that even though the legal opinion might be adverse to the passing of such a rule it should nevertheless be done. After discussion it was proposed by Dr. Broomberg, seconded by Mr. Sweetapple, that the passing of an ethical rule on the lines suggested by the Southern Transvaal Branch should not be agreed to as it would not serve any useful purpose. An amendment was proposed by Dr. Cox, seconded by Dr. Geerling, that further discussion on this subject be deferred and that the matter be brought up again under Item 10 of the Agenda. On being put to the vote, the amendment was *carried nem. con.*

10. *Honorarium in the Transvaal*. The Medical Secretary reported that 90 members had signed waiver forms. Most of them had agreed to waive the whole amount due to them in favour of the Benevolent Fund, while others had agreed only to waive a percentage.

The Honorary Treasurer, Dr. du Toit, and others expressed deep appreciation of the generous action of these members. *Noted*.

11. *Amoebiasis Control*: A letter from the Secretary for Health was submitted, in which it was pointed out that the control measures which had been adopted in Natal had been withdrawn on the representations of the various local authorities. *Noted*.

12. *Fees for Medical Practitioners Giving Evidence in Court*: Correspondence from the Secretary for Justice was submitted. The Medical Secretary reported that the Executive Committee recommended that the Secretary for Justice be notified that if and when the matter is brought up under review the Association should be informed so that it might make suitable recommendations.

The recommendation of the Executive Committee was *adopted nem. con.*

13. *Nurses' Examination Papers*: Dr. Shadick Higgins reported on this subject, giving Council information as to the discussions which had taken place in open meeting of the Nursing Council.

The Medical Secretary reported that the Executive Committee recommended that the Minister of Health be asked to appoint a Committee of Inquiry into the Nursing Services of the Union, with particular reference to the examination of student nurses.

It was proposed by Dr. Schaffer, seconded by Dr. du Toit, that the recommendation of the Executive Committee be accepted. An amendment was proposed by Dr. Goldberg, seconded by Dr. Joubert, that the word 'training' should be included in the recommendation. This amendment was accepted by the proposer and seconder of the motion.

A further amendment was proposed by Dr. Broomberg, seconded by Dr. Meltzer, that the words 'and the conditions of service of all nurses' be added to the end of the recommendation. This amendment was also accepted.

The recommendation as amended, reading: 'That the Minister of Health be asked to appoint a Committee of Inquiry into the Nursing Services of the Union, with particular reference to the training and examination of student nurses and the conditions of service of all nurses,' was put to the vote and *carried*.

Council further *agreed* that a memorandum should be drawn up and submitted to the Minister with the resolution. After discussion it was agreed that the drawing up of the memorandum be left to the Medical Secretary in conjunction with Dr. Shadick Higgins, Dr. Schaffer and Dr. Goldberg.

14. *Heart Examination Forms for Insurance Companies*: On behalf of the Southern Transvaal Branch, Dr. Alice Cox moved 'That where a general practitioner, who has not examined the applicant for insurance, is asked to examine the applicant and complete a heart form, the fee should be £1. 11s. 6d. Where a specialist physician is the doctor, he is entitled to charge the usual examination fee, i.e. £4 4s.' Dr. Cox moved further, seconded by Dr. Geerling, that Federal Council express approval of the fees suggested by the Southern Transvaal Branch in respect of the cardiac examination and report required by insurance companies. This examination should include electrocardiographic reports.

After discussion an amendment was proposed by Dr. Joubert, seconded by Dr. Bell, that when an insurance company asks for a special examination of a patient's heart, the following fees shall be applicable:—

(a) General Practitioners: £1 11s. 6d.

(b) General Practitioners using an electrocardiograph apparatus: £2 12s. 6d.

(c) A Specialist with or without an electrocardiogram: The usual fee charged by a Specialist for a full consultation.

With the consent of her seconder, Dr. Cox withdrew her proposal.

The amendment was put to the vote as a substantive motion and *carried*.

MATTERS DEALT WITH BY THE EXECUTIVE COMMITTEE

15. *Committee of Inquiry into Motor Vehicle Insurance Act*: The President reported that the attention of the Association had been drawn to the appointment of a Committee of Inquiry into the Motor Vehicle Insurance Act and that Drs. Braun and Pirie had been asked to form a small committee to draw up a memorandum. They had co-opted Dr. G. T. du Toit for this purpose. In due course the report had been presented and the members had acted as a deputation to the Committee of Inquiry.

Dr. Pirie then gave a verbal report on the reception which had been accorded the deputation, saying that although they had been received sympathetically they had been informed that most of the items which had been raised were outside the terms of reference of the Committee of Inquiry.

The President thanked Dr. Pirie for his report, which was *noted*.

16. *Judicial Committee of Inquiry into Operations of Leucotomy, etc.*: The Medical Secretary reported that a notice had appeared in the *Government Gazette* drawing attention to the setting up of a Committee of Inquiry, and that he had also been informed of this by the Registrar of the South African Medical and Dental Council. The Executive Committee had agreed that Dr. Braun should be asked to act on behalf of the Executive Committee with Dr. Alice Cox and Mr. Krynauw as co-opted members. A memorandum was prepared and forwarded to the Commission. In due course the committee would act as the Association's deputation to the Committee of Inquiry. *Noted*.

It was proposed by Dr. Geerling, seconded by Dr. Cox, that the Association should be legally represented by senior counsel at the Judicial Committee of Inquiry.

After some discussion it was proposed by Dr. Geerling, seconded by Dr. Shapiro and *resolved* that Council go into committee.

It was later proposed by Dr. Pirie, seconded by Dr. Broomberg and *resolved* that Council go out of committee.

On being put to the vote, Dr. Geerling's resolution was *lost*. Council *agreed* that the memorandum which had been submitted to the Committee of Inquiry should be considered as coming from Federal Council.

17. *Committee of Inquiry into Blood Transfusion Services*: The Medical Secretary reported that a notice had appeared in

the *Government Gazette* that a Committee of Inquiry into Blood Transfusion Services had been appointed. After consideration the Executive Committee had agreed that the Branches should be approached and invited to give their own evidence before the Committee. He mentioned further that various Branches had submitted memoranda which would be discussed by the Committee of Inquiry in due course. *Noted.*

18. *Presidency of the British Medical Association*: The Medical Secretary reported that after the cancellation of the Joint Meeting Dr. Sichel had been approached by the Chairman of the Council of the British Medical Association to continue as President-Elect of the British Medical Association and to be their President for the coming year. On the advice of the Executive Committee Dr. Sichel had agreed to this. He added that the Executive Committee was unanimous in agreeing that Dr. Sichel should accept the honour held out to him by the British Medical Association and that he should proceed to London to be installed as President of the British Medical Association.

Council *approved* this recommendation *with acclamation.*

Dr. Pirie rose to express the appreciation of members of the Council at the action of the Council of the British Medical Association, and he read a draft letter which he recommended should be sent to the British Medical Association, expressing this appreciation. Council *accepted* Dr. Pirie's recommendation *with acclamation.*

Dr. Pirie was supported by Dr. du Toit, the Honorary Treasurer.

In replying, Dr. Sichel stated that he would convey to the members of the British Medical Association the fraternal greetings of the members of the Medical Association of South Africa. *Acclamation.*

19. *Visit of the Editor to the Meeting of the Fifth General Assembly of the World Medical Association*: The President reported that the Medical Association of South Africa had been represented at the previous General Assemblies and that on this occasion it was proposed that the Editor should attend to represent the Association and also to be present at a conference of Editors of Medical Journals. While overseas, Dr. Shapiro would also act on behalf of the National Road Safety Organization in obtaining information regarding the determination of blood alcohol. He pointed out that part of the expenses incurred by Dr. Shapiro would probably be met by that Organization. He reported further that the Executive Committee recommended that Dr. Shapiro should be sent to represent the Association and at its expense. Council *agreed with acclamation.*

It was proposed by Dr. du Toit, seconded by Mr. Goldschmidt and *resolved nem. con.* that the expenses of both the President and the Editor in their visits overseas should be met by the Association.

20. *Sims Travelling Fellowship*: The President stated that the Executive Committee had considered the question of the Sims Travelling Fellowship for future years and recommended that an approach be made to the proper authorities suggesting that Mr. L. R. Broster, F.R.C.S., be invited to become a Sims Travelling Fellow in 1952.

The Medical Secretary read the recommendation of the Executive Committee, as follows:—'That it be recommended to the Royal College of Surgeons of England, the Royal College of Physicians of London, the Royal College of Obstetricians and Gynaecologists and the Secretaries of the British Medical Association in Australia and New Zealand that Mr. L. R. Broster, F.R.C.S., be appointed Sims Travelling Fellow for 1952.' The recommendation was put to the vote and *carried nem. con.*

21. *Public Liability Insurance*: The Medical Secretary read a letter from the Atlas Assurance Company, in which it was stated:—'Where we are requested to extend a doctor's liability policy to indemnify named auxiliaries or assistants other than qualified medical practitioners, we are prepared to do so for a small additional premium. This additional premium will depend on the limits of the policy . . .'. *Noted.*

REPORT OF CENTRAL ETHICAL COMMITTEE

22. *Revision of Rules of Procedure*: The Medical Secretary reported that the question of the revision of the Rules of Procedure in Ethical Matters of a Branch was being dealt with by the Committee, which had now agreed that three of its members—Dr. Sichel, Mr. Goldschmidt and Dr. Shadick Higgins—together with the Association's lawyers in Cape Town, should prepare a draft of a new procedure which would then be submitted to all members of the Central Committee for report back to Council at its next meeting. *Noted.*

REPORT OF PARLIAMENTARY COMMITTEE

23. *Adoption of the Report*: The Convener, Dr. J. P. de Villiers, formally moved the adoption of the Report as circulated. This was seconded by Dr. Schaffer. *Carried.*

24. *Amendment of Medical, Dental and Pharmacy Act (1951)*: Dr. Shapiro said that it was not clear what Section 1 of the Amending Bill really meant, and after discussion it was proposed by Dr. Shapiro, seconded by Dr. de Villiers and *resolved nem. con.* that consideration of Section 1 of the Amending Bill (1951) be referred to the Parliamentary Committee for report at the next meeting of Council.

(*Council adjourned for lunch at 1 p.m. and resumed at 2.25* p.m.)

REPORT OF HEAD OFFICE AND JOURNAL COMMITTEE

25. *Post-Assistant Medical Secretary*: The Chairman reported that Dr. L. M. Marchand of Robertson had been appointed to this post and had agreed to assume duty on 1 May. He added that the Executive Committee had approved the appointment.

It was proposed by Dr. Wagner, seconded by Dr. Geerling and *resolved* that the action of the Executive Committee in approving the appointment of Dr. Marchand be confirmed.

26. *History of Medicine in South Africa*: The Chairman reported on the progress being made in this work. *Noted.*

27. *Leipoldt Memorial Medal*: Rules for the award of this medal were submitted as follows:—

'The Leipoldt Memorial Medal was instituted in 1951 to commemorate the life and work of the late Dr. Christiaan Louis Leipoldt who, from 1927 to 1944, was Medical Secretary of the Medical Association of South Africa and Editor of the *South African Medical Journal.*

'Rules:

'1. The Leipoldt Memorial Medal may be awarded for the most outstanding paper contributed to the *South African Medical Journal* in any one year by a General Practitioner.

'2. The award will be made by the Head Office and Journal Committee of the Medical Association of South Africa which will act as the adjudication committee.

'3. The decision of the Committee shall be confirmed by the Federal Council at its next following meeting, when it shall become final and irrevocable.

'4. Any General Practitioner who is a candidate for this award must be in active general practice, or his paper must be based on experience gained in general practice.

'5. The award of the Leipoldt Memorial Medal does not necessarily exclude the recipient from other awards such as the Hamilton-Maynard Memorial Medal.

'*Note*: Papers published in the *Journal* before the end of 1949 shall not be eligible for the award.'

After discussion it was proposed by Dr. Geerling, seconded by Dr. Deale and *resolved* that the rules as submitted be adopted.

28. *Insignia for President's Wife*: The Chairman reported that this badge had been completed and had been presented to Mrs. Sandes. *Noted.*

29. *Alterations to Medical House*: The Chairman reported that the alterations planned at Medical House, Cape Town, had been completed and that the new offices were being occupied. *Noted.*

30. *Agency Department*: The Chairman reported that progress was being made in the Agencies in Johannesburg and Cape Town and that it was expected that a third Agency in Durban would soon be opened.

In response to a question by Dr. Collins, the Medical Secretary stated that close liaison was kept up between the two branches of the Agency. *Noted.*

31. *Hamilton-Maynard Memorial Medal*: The Chairman stated that the Head Office and Journal Committee recommended that the Hamilton-Maynard Memorial Medal for 1950 be awarded to Mr. R. A. Krynauw of Johannesburg in

recognition of his paper entitled 'Infantile Hemiplegia Treated by Removal of One Cerebral Hemisphere' which was published in the *Journal* of 8 July 1950. Council *approved* this award *with acclamation*.

32. *Post-Assistant Editor*: The Chairman stated that Dr. Walton had resigned his position as part-time Assistant Editor as he was applying for a full-time post at the Groote Schuur Hospital. He added that the Committee recommended to Council that the question of appointing a full-time Assistant Editor be left to it for consideration and that the Committee be given power to act when it considered the time to be ripe for such an appointment to be made.

Acceptance of this recommendation was proposed by Dr. du Toit, seconded by Dr. Pirie. Council *agreed*.

33. *Letter from the Editor*: The Chairman submitted the report and a recommendation from the Committee 'that in view of all the circumstances associated with the posts and with the individual appointments respectively of the Medical Secretary and the Editor, the request made by the Editor in his letter of 13 October 1950 to Federal Council for increased salary be not acceded to.'

The Chairman asked that any discussion on this matter should be dealt with in committee. Council *agreed*.

On coming out of committee, Council *resolved* that a recommendation of the Executive Committee be accepted, reading:—'That in view of the growth of the Association and the increased work resulting therefrom, a committee consisting of the newly-appointed members of the Head Office and Journal Committee, together with a member invited from each of the Branches, should meet before the next meeting of Council to consider the administration of the Association with particular reference to the salary scales and remuneration generally of the senior officials.'

An addendum was proposed by Dr. M. Shapiro, seconded by Dr. Turton and *carried*, 'that in reviewing the salaries of officers of the Association, the Committee shall ensure that the salary scales, emoluments and status in their respective offices of the Editor and Medical Secretary of the Association shall be equivalent'.

Mr. Goldschmidt asked that his vote be recorded against the addendum as he did not wish the committee to be fettered in any way.

The Chairman then moved the adoption of the Committee's Report as a whole, seconded by Dr. Goldberg. *Carried*.

REPORT OF THE MANAGEMENT COMMITTEE OF THE BENEVOLENT FUND

34. *Grants for 1951*: Council *confirmed* the action of the Executive Committee in agreeing to grants as follows:—Mrs. L. A. £120; Mrs. R. D. £120; Mrs. W. F. £75; Mrs. D. G. F. £50; Mrs. O. G. F. £72; Mrs. P. C. L. £60; Mrs. A. M. £120; Mrs. A. M. P. £120; Mrs. K. R. £60; Dr. and Mrs. E. M. W.-R. £180; Mrs. F. W. £60; Miss B. W. £50; Dr. C. C. A. £120; Mr. H. v. d. P. £100; Dr. M. O. £120.

35. *Grants to Dependants of Non-Members*: The Management Committee recommended that Mrs. A. be granted £96 and Mrs. E. C. £120 for the year 1951.

Ballot votes were taken in each case and the result was *unanimous approval* of these grants.

36. *New Grant to Dependant of Non-Member*: Council *agreed* by ballot that an amount of £60 for 1951 be paid to Mrs. S. R.

37. *Increased Grant*: Council agreed to the recommendation of the Management Committee that at the request of the Branch Council of the Natal Coastal Branch the grant to Mrs. K. R. be increased by £60 per annum to £120 per annum.

38. *Collections on Behalf of the Benevolent Fund*: The Chairman suggested that other Branches might wish to follow the example of the Cape Western Branch, where a collection box was now available at meetings for contributions which members might wish to make. He asked members to go back to their Branches and do all they could to stimulate the giving of donations and other contributions to the Fund.

He then moved the adoption of the Report of the Management Committee of the Benevolent Fund as a whole. *Carried*.

39. *Further Appeals for Benevolent Fund*: Arising out of the Report of the Management Committee, several suggestions were made regarding appeals which might be made to members of the Association to augment the Fund. Finally the Vice-President suggested that this question be left to the Head Office and Journal Committee. Council *agreed*.

40. *Delay in the Payment of Grants*: Dr. Broomberg pointed out that delay sometimes took place before necessitous persons could be helped.

The Medical Secretary outlined the procedure which had to be followed by the Management Committee and suggested that there would be less delay if the Management Committee were empowered to make greater immediate grants which could be later confirmed by Federal Council.

It was proposed by Dr. Shapiro, seconded by Dr. du Toit and *resolved* that the Management Committee be empowered to grant immediate assistance up to an amount of £50 to any one beneficiary, which should subsequently be confirmed by Federal Council.

41. *Financial Report*: The Honorary Treasurer presented his Report as follows:—

'Unfortunately the audited Balance Sheet and Financial Statement for 1950 are not yet completed at the time of this report, but it is estimated that the year ended with a nett surplus—i.e. an excess of income over expenditure—of £5,106 4s. 5d.; this being the second year of the publishing of a weekly *Journal*.

'Revenue from *Journal* subscriptions has been maintained at the level of £4,940, whilst revenue from Advertising increased from £25,300 in 1949 to £26,690 in 1950.

'This being the first year that the *S.A. Journal of Clinical Science* (incorporating the *Journal Clinical Proceedings*) was published and issued quarterly, the year ended with an excess of income over expenditure of £197 14s. 1d. Administration expenses, however, for instance salaries, were not reckoned against this publication.

'The cost of printing the above publication amounted to £823. Other chief expenses were Advertising Commission £60, Stationery £77, Blocks £98. The revenue amounted to:—

Subscriptions	£568
Advertising	718
Sundries	3
	£1,289

'There was a slight decrease in the cost of printing the *S.A. Medical Journal*, namely £12,945 for 1949 against £12,917 in 1950.

'The expenditure on Advertising Commission has decreased from £3,258 for 1949 to £2,874 for 1950.

'It is estimated that our Accumulated Funds will increase from £24,328 at the end of 1949 to £29,434.

Benevolent Fund:

'The Revenue of the Benevolent Fund for 1950 is as follows:—

Donations	£751
Votive Cards	202
Services Rendered	493
	£1,446

Plus £1,015 interest on investments.

'It was decided by Federal Council that the interest earned the previous year, plus an amount equal to the interest earned, could be used for grants. The amount available for this purpose for 1951 will then be £2,030.

'The sum of £1,296 was paid out in grants during 1950. The accumulated funds as at 31 December 1950 were £26,343.

'As Honorary Treasurer of the Fund, I would like to thank all contributors and feel that they should know that all the donations they have made have been gratefully received and are being used to good purpose.'

Dr. Deale and others congratulated the Honorary Treasurer on his report.

The adoption of the Report was then moved by the Honorary Treasurer, seconded by Dr. Gie and *carried*.

REPORTS OF SUB-COMMITTEES

42. *Workmen's Compensation Act Sub-Committee*: In presenting his Report, the Convener, Dr. Meltzer, stated that although the Commissioner was in favour of free choice of

doctor he was unwilling to approach the Minister in order that this principle might be introduced to the Act. *Noted.*

43. *Case of an Injured Railwayman*: The Convener reported that a Railway workman had been severely injured at a level crossing and a private practitioner had been called by the nearest stationmaster to attend to the workman. His account had been rendered in terms of the Medical Aid Society tariff but had later been computed by the Railway Sick Fund in terms of the Workmen's Compensation Act schedule at some £20 less. The question arose as to whether the Railways were entitled to refuse to pay a private practitioner's fees when he was called to attend a railway employee and was not under contract to the Railways as a Railway Medical Officer.

After discussion it was proposed by Dr. Meltzer, seconded by Dr. Deale and *resolved nem. con.* that legal opinion be sought as to whether the schedule of fees laid down under the Workmen's Compensation Act is applicable in the case of injured workmen who are employed by organizations which have contracted out of the Act and where the work is undertaken by private practitioners.

44. *Free Choice of Doctor*: Dr. Shapiro stated that the official attitude of the Transvaal Provincial Administration to injured workmen was that it was the hospital's responsibility only to do such first-aid treatment as might be necessary. Thereafter the injured workman should exercise his choice of doctor, if at all possible. He urged that this matter be clarified with the Workmen's Compensation Commissioner as a definite principle was involved.

45. *Definition of an Accident*: Dr. Shapiro stated that it was imperative that the question of the definition of an accident should be settled. The Workmen's Compensation Commissioner charged different rates for different employments as different industrial hazards were involved. He was not satisfied with the Commissioner's ruling as regards what was or was not an accident and he considered that if no satisfaction could be got from the Commissioner the Association should approach the Trades and Labour Council in order to see what that body considered to be a reasonable definition.

46. *Private Arrangements with Employers*: It was proposed by Dr. Shapiro, seconded by Dr. Turton and *resolved nem. con.* that the Federal Council is aware that practitioners have entered into private arrangements with employers and disapproves of this procedure. The correct and proper course for a medical practitioner to follow when an injured workman is sent to him by an employer is to inform the workman that he has free choice of doctor and to ask him whether he elects to be treated by the practitioner concerned.

47. *Adoption of the Report*: The adoption of the Report of the Workmen's Compensation Act Sub-Committee was then moved by Dr. Meltzer, seconded by Dr. Gie and *carried nem. con.*

At this stage the President drew attention to the length of the Agenda and stated that it would be necessary for the Council to meet on the following evening.

(Council adjourned at 6 p.m.)

FRIDAY, 13 APRIL

(The meeting commenced at 9.25 a.m.)

48. *Conference of Interested Bodies on the Question of 'Farming Out'*: Dr. Meltzer reported on the conference which had been held in Pretoria after the last meeting of Federal Council, which he said had achieved no very satisfactory result. Regarding the Railways, Dr. Meltzer pointed out that they had no separate Compensation Fund but that Workmen's Compensation Act cases were dealt with under the ordinary Sick Fund rules. He added that where cases were dealt with by specialists outside the Sick Fund, those specialists were paid. Normally cases were dealt with by appointed medical officers who received no extra remuneration for their services. *Noted.*

49. *Vanderbijl Park Research Fund*: Dr. Meltzer stated that this matter was receiving the attention of the South African Medical and Dental Council, and Dr. Black added that the matter had been referred back to the Executive Committee of the Council and that we would no doubt hear more of it at a later stage. *Noted.*

REPORT OF THE SUB-COMMITTEE ON THE MEDICAL, DENTAL AND PHARMACY ACT

50. *Alterations to the Ethical Rules*: The President suggested that Dr. Meltzer, in presenting his Report, should speak from the platform and be assisted by the Medical Secretary in putting forward the proposed amendments to the Ethical Rules of the South African Medical and Dental Council.

The old rules were taken seriatim and compared with the new rules as follows:—

(1) *Advertising.*

1. 'Advertising himself with a view to his professional gain or permitting such advertisement.' *Accepted* by Council.

2. 'Advertising in the lay press or by broadcasting; arranging or inspiring or permitting reports, interviews, articles or notices of any description referring to himself in a manner calculated to attract patients.' *Accepted* by Council.

3. 'Issuing to the public or permitting to appear in a public place cards, handbills or pamphlets or any other communications in connexion with his practice, except to bona fide patients, intimating change of address, dissolution of partnership and the like, in which case the communications themselves must bear the name of the patient to whom they are addressed and must be enclosed in a sealed envelope.' *Accepted* by Council.

4. 'Publishing or allowing to be published in the official telephone directory any information other than his name and profession and that of his active partner, if any, his speciality, if any, and address, or publishing these in any other but the ordinary type of such publication. In the case of death or retiral of a partner, his name shall not be retained either separately or together with others for a period exceeding twelve months after such death or retiral.' *Accepted* by Council.

5. 'The printing on envelopes of any information other than a return address and the practitioner's name without any qualification, in case of non-delivery.' *Accepted* by Council.

6. 'Permitting the appearance in the lay press of his opinion on medical or dental subjects with his name appended thereto; provided that this rule shall not apply to whole-time public medical or dental officials acting in their official capacities; or to officers of a medical or dental association or society acting in an official capacity on the instructions of such association or society, or to practitioners not in private practice; or to any communication dealing solely with questions purely of academic interest; public health, hospital administration, medico-political matters, dentistry and the like, wherein the co-operation of the public is necessarily sought in order to give practical effect to principles already generally accepted by the profession.

Note: A practitioner permitting the appearance in the lay press of his views on medical and dental subjects will be held personally responsible that such publication does not constitute advertising.' *Accepted* by Council.

7. 'Delivering an address or lecture on a medical or dental subject before a lay assembly; provided that this rule shall not apply to whole-time public medical or dental officials acting in their official capacities or to officers of a medical or dental association or society acting in their official capacities on the instructions of such association or society, or to practitioners not in private practice, or to any lecture or address on a medical or dental subject given with the sanction in writing of the medical or dental association or society of the area in which such lecture or address is proposed to be given.

Note: The practitioner delivering the lecture or address will be held personally responsible that his lecture or address does not constitute advertising.' *Accepted* by Council.

General Notes to Rule 1.

i. 'A medical practitioner or dentist in general practice may send notifications of having commenced practice to other medical practitioners or dentists practising in the same area, in which case the communications themselves must bear the name of the practitioner to whom they are addressed and must be enclosed in a sealed envelope.' In this case Council *agreed* to recommend that the words 'practising in the same area' should be deleted.

ii. 'A medical practitioner or dentist who has been registered as a specialist may send notifications to other medical practitioners or dentists of having commenced practice in his speciality, in which case the communications

may contain only his name, address, qualifications and his speciality, and the communications themselves must bear the name of the practitioner to whom they are addressed and must be enclosed in a sealed envelope.' Council *agreed* to recommend that the words 'must bear the name of the practitioner to whom they are addressed and' should be deleted.

iii. 'A medical practitioner or dentist in general practice may restrict his practice to a particular subject of medicine or dentistry, but is not permitted to circularize his colleagues or other persons to this effect, since this may create the impression that he is a specialist.' *Accepted* by Council.

(3) *Name Plates.*

'In Note (i) delete the words "The use of the term American Dentist or similar title is not allowed". Add the following new note: (ix) Where the Companies Act requires the names of directors of the company to appear in any document, a medical practitioner or dentist who is a director of the company must so permit his name to appear, but he shall not use any professional qualification or the term "Doctor" in connexion with his name.' *Accepted* by Council.

(16) *Professional Secrecy.*

'Divulging verbally or in writing any information which ought not to be divulged regarding the ailments of a patient except with the express consent of the patient or, in the case of a minor, with the consent of his guardian, or in the case of a deceased patient, with the consent of his next of kin or the executor of his estate. *Note*: In a court of law, professional secrecy should be contravened only under protest after direction from the presiding judge.' Council *agreed* to recommend that the word 'judge' be altered to 'officer'.

(17) *Certificates.*

'Granting a certificate in his professional capacity unless he is satisfied from personal observation that the facts are correctly stated therein, or has qualified the certificate by the words "as I am informed by the patient".' *Accepted* by Council.

(20) *Secret Remedies, etc.*

(1) 'Making use in the conduct of his practice—

(a) of any form of treatment, apparatus or technical process, which is secret or is claimed to be secret;

(b) of any apparatus which proves upon investigation to be incapable of fulfilling the claims made in regard to it.' *Accepted* by Council.

(21) *Consulting Rooms.*

1. 'Having consulting rooms for private practice with the entrance through, or with the name plate at, the entrance to a chemist's shop.' *Accepted* by Council.

2. 'Sharing consulting or waiting rooms with persons not on the medical or dental registers.' *Accepted* by Council.

3. 'Using in connexion with his consulting rooms the term hospital, clinic or any other similar name which might lead the public to believe that the consulting rooms are part of a hospital, clinic, nursing home or other similar institution, or have features differing from those of ordinary consulting rooms. The use on name plates, note paper or elsewhere of a designation such as Dr. X. . . . Clinic or Hospital, is therefore not permissible.' *Accepted* by Council.

(24) *Council's Statutory Duties.*

1. 'Any wilful act or omission which prevents or is calculated to prevent the Council or the Registrar from carrying out its/his statutory duties.' *Accepted* by Council.

The Medical Secretary then read:

'The Executive Committee is considering a rule relating to doctors' illuminated name plates, fluorescent signs, etc.'

Dr. Black stated that this matter had been dropped. *Noted.*

Arising out of this, Council *agreed* to recommend that it be permissible for a practitioner to use a red light outside to indicate the entrance to his surgery if he wishes so to do.

Arising further out of this Report, Dr. Geerling spoke on the question of radiologists owning X-ray apparatus contained in private nursing homes within the Johannesburg area and asked whether it would not be more correct for the nursing homes to instal their own equipment which could be used by all radiologists practising within the area, admitting that he realized that it would be better for X-ray apparatus not to be used by more than one person.

This raised the question of the submission of further ethical rules to the South African Medical and Dental Council for consideration. Dr. Meltzer stated that his Sub-Committee had considered certain other rules but had not had time to formulate them. He suggested that his Sub-Committee give further consideration to this matter and submit a memorandum to Federal Council members individually by correspondence. After discussion it was *agreed* that this method be not followed, and it was proposed by Dr. Shapiro, seconded by Dr. Geerling and *resolved* that the Sub-Committee draw up a report for submission to Council at its next meeting.

Dr. Meltzer then moved the adoption of his Report, which was *carried with acclamation.*

51. *Sub-Committee to Interview the S.A.R. & H. Sick Fund Board*: The President briefly outlined the position to date and spoke of the interview which he and the Medical Secretary had had with the Minister of Transport and the General Manager of Railways.

The Medical Secretary read a letter in which it was stated that the General Manager would meet representatives of the Federal Council to discuss policy.

After discussion it was *agreed* that this invitation should be accepted and that the meeting would be held in Cape Town at a date to be arranged.

52. *Sub-Committee to Advise the Controller of Imports*: A written report was submitted by the Convener, from which the Council *noted* that the Committee continued to carry out its task of advising the Controller of Imports.

53. *Sub-Committee on Post-Mortem Examinations*: A written report was submitted by the Convener, from which Council *noted* that representations had been made to the Medical Council to hold a round-table conference of interested bodies but that the Committee had been told that the Council had requested the Minister of Health to appoint an inter-departmental committee to go into the whole matter of the performance of post-mortem examinations.

54. *Sub-Committee for Liaison with the Pharmaceutical Society of South Africa*: The Medical Secretary read a report submitted by the Convener, from which the Council *noted* various complaints of dispensing by medical practitioners, one of which it instructed should be brought to the notice of the Natal Inland Branch.

55. *Sub-Committee on Income Tax Assessment*: The Convener presented his Report, from which Council *noted* that the brochure would be ready for sale before the next income tax assessment was made. Council also *noted* that, while copyright would vest in the author, for a single payment of 50 guineas the Association would have the exclusive right to publish the work including all amendments during a three-year period.

The President thanked Dr. Bell for the work and the trouble he had gone to in this regard.

Council *agreed* that the question of publication of the brochure be left to the Head Office and Journal Committee, and that that Committee would also decide on a title for the brochure.

56. *Sub-Committee to Advise the National Road Safety Organization*: The President made a short report on the work of this Committee, stating particularly that the Committee had devoted considerable time to certain of the technical problems in connexion with the taking of blood samples from persons accused of being under the influence of liquor, the transport of these samples and the estimation of their alcohol content. Council *noted* this report.

(Council adjourned for lunch at 1 p.m. and resumed at 2.30 p.m., when the Vice-President occupied the Chair)

REPORT OF THE CENTRAL COMMITTEE FOR CONTRACT PRACTICE

57. *Preliminary Remarks*: Presenting his Report, the Chairman of the Committee, Dr. Green, referred to the return of Dr. Gie after his illness, which was *noted with acclamation* by Council. He also thanked the Medical Secretary for his assistance. *Noted.*

58. *Stewarts & Lloyds Medical Benefit Fund*: It was *noted* that the Vereeniging Division had failed to reach a satisfactory solution in connexion with this Fund, but the Committee recommended that it should be recognized if it would agree to operate as a Medical Aid Society in the Vereeniging area in the same way as it operated as such a Society in other centres. Council *agreed.*

The Committee further recommended that the Southern Transvaal Branch should undertake to negotiate further in this matter. Council *agreed*.

59. *United Tobacco Companies (Bloemfontein)*: The Committee recommended that this Medical Aid Society be recognized subject to certain principles being reaffirmed. Council *agreed*.

60. *Vanderbijl Park Medical Benefit Fund*: The Committee recommended that this Benefit Society be not recognized as it catered for an income group which was higher than that recognized by the Association for Benefit Societies and should rather practice as a Medical Aid Society. After much discussion Council *agreed*.

61. *New Applications for Approval*: The Committee recommended that the following Medical Aid Societies be recognized:—

(a) Eastern Province Newspapers Medical Aid Society.
(b) G. H. Langler & Co. Medical Aid Society.
(c) African Oxygen & Acetylene Medical Aid Society.
(d) Randle Bros. & Hudson (Durban) Medical Aid Society.
(e) The 'Rennie' and 'The Consolidated' Employees' Medical Aid Fund. Council *agreed*.

62. *Rules to which Sick Benefit Societies should Conform before Receiving Approval by the Association*: The Committee submitted a list of new rules. The Chairman explained the differences between the new rules and those which had previously been in force.

After considerable discussion Council *approved* the rules in the following form:—

'(1) *Membership*. This should be confined to those earning less than a basic salary or wage of £600 per annum in the case of a person with dependants and £300 in the case of a person with no dependants. In certain cases, however, where a Society can show that the percentage of members whose basic salary exceeds £600 per annum is more than 5% but less than 10%, approval may be granted if a sliding scale of subscriptions in proportion to their earnings is applicable and a higher capitation fee than the minimum applied—the capitation fee to be fixed by negotiation between the Branch and the Society concerned. No person earning a basic income above £1,500 per annum should be eligible for membership of a Sick Benefit Fund with a closed panel.

'(2) *Panel of Doctors*: The Medical Association of South Africa favours an open panel of general practitioners.

'(3) *Specialists' Appointments*: Societies shall be entitled to appoint their own specialists on approved salaries or on a membership rate of payment as laid down by the Association. Alternatively they may have a free choice of specialist on the Medical Aid Society Tariff of Fees.

'(4) *Remuneration of Appointed Medical Officers*:

(a) The rate of payment of medical officers should be not less than 22s. 6d. per capita per annum for European and 14s. per capita per annum for non-European members, and the same rate should apply to dependants if included in the membership of the Societies. The salary paid to medical officers should be based on this per capita rate. Alternatively, where membership of a Society includes dependants, the payment of medical officers should be on the basis of 70s. per member per annum for Europeans and 48s. per member per annum for non-Europeans. It is preferable that payment be made at not longer than quarterly periods.

(b) The per capita rate of remuneration shall not include dispensing and medicines.

(c) Travelling allowances should be provided for in addition to the per capita rate where the medical officer has to visit a patient at a distance of more than four miles from his surgery or his residence, whichever is the nearer. Although the usual mileage charge varies in different areas, on the average it is 2s. 6d. per mile both ways. Mileage charges only to come into force after four miles in urban areas.

(d) If conditions of membership entail a medical examination and full report for entry, then the Society shall be responsible for the fee and this should be £1 1s. per member and 10s. 6d. for each dependant.

(5) *Terms of Contract with Medical Officer*: These should be clearly stated and be open to any bona fide applicant for the post. Mileage charges should be arranged with the Medical Officer before he is appointed. It will be necessary for these terms of contract and the Constitution of the Benefit Society to be submitted to the Medical Association of South Africa before appointments are advertised.

(6) *Subscriptions*: A sliding scale of subscriptions paid by members according to their incomes will be viewed with approval by the Association and will be obligatory under certain conditions as stated in Rule 1.

(7) *Benefit Fund or Sick Benefit Fund*: In the case where the employees and/or the employer start a benefit fund in any industrial or other organization, the Medical Association of South Africa is against any person residing in that area but not employed by the organization being included as a member of the fund.

(8) *Medicines*: Where the cost of medicine is included as a benefit to members it is an advantage to the Society that the member shall pay a small percentage of the cost; but the exclusion of this rule shall not preclude recognition and approval by the Medical Association of South Africa.

(9) *South African Medical Council Rule*: No medical practitioner can apply for any appointment unless such appointment has been advertised in the lay and medical press.

(10) *The Minimum Number of Members*: The minimum number of members laid down for the formation of a Benefit Society should be 100 or more in order to be considered for approval.

(11) *It is desirable that only members of the Medical Association of South Africa* should be considered for appointments as medical officers to Benefit Societies.

(12) *Subsidiary and Associated Companies or Firms*: Benefit Societies must obtain the approval of the Medical Association of South Africa before accepting as members the staff of subsidiary and associated companies or firms.

(13) *Forfeiture of the Association's Approval*: Any indication of a society attempting to exploit the medical profession shall lead to forfeiture of the Association's approval. The Association reserves the right to withdraw its approval from any medical benefit society by giving three months' notice for a review of the conditions of service and terms of appointment in respect of its medical officers.

(14) *Advertising of Appointments*: Appointments to Medical Benefit Societies shall be advertised in the *South African Medical Journal*, and advertisements so submitted for publication shall be accompanied by:—

(a) The Constitution, Rules and Regulations of the Society.
(b) Conditions of service and remuneration for the doctor.
(c) Income group of the Society.
(d) The number and type of membership of the Society.'

Following the acceptance of these Rules, it was proposed by Dr. Gie, seconded by Dr. Struthers and *resolved* that the question of Benefit Society rates payable to specialists be referred back to the Central Committee for Contract Practice for review, provided that the present scales operate in the meantime.

63. *South African Association of Benefit Societies*: The Chairman referred to an article which had appeared in the *Sunday Times* and also to a letter which he had received from the Secretary of the South African Association of Medical Benefit Societies in this regard.

At this stage it was proposed by Dr. Geerling that a joint committee of the Northern and Southern Transvaal Branches should consider the question of the remuneration for specialists on a per membership rate for appointment to Benefit Societies. Council *agreed*.

Dr. Geerling then moved, seconded by Dr. Shapiro, that this Joint Committee of the two Branches should at the same time become a Vigilance Committee of the Council to watch the development of the affairs of Medical Benefit Societies, and that it be empowered to take action if and when required, reporting on its actions to the Council. Council *agreed*. Council further *agreed* that the Committee have powers of co-option.

64. *Relations of the Medical Aid and Benefit Societies to the Medical Profession*: A lengthy memorandum had been submitted by the Southern Transvaal Branch which the Chairman said his Committee had not had time to discuss.

Dr. Bell stated that the report had been submitted merely to assist the Council in considering the amendments to the Tariff of Fees for Approved Medical Aid Societies. *Noted*.

65. *Amendment of the Tariff of Fees for Approved Medical Aid Societies*: The Committee recommended that a small

sub-committee consisting of Dr. Gie, Dr. Tonkin and Dr. Green, with power to co-opt, should meet representatives of the Medical Aid Societies for preliminary discussions in Cape Town. Following these discussions a full meeting of the Central Committee for Contract Practice with representatives of the Medical Aid Societies would be held in Johannesburg as soon as possible thereafter in order to bring the matter to finality. Council *agreed*.

Council further *agreed* that, if possible, the amended Tariff should operate as from 1 July 1951.

The Committee further recommended as a basis for negotiation:—

(a) That there be an overall increase in the Tariff of at least 10%.

(b) That there be a difference between fees for visits and consultations for general practitioners.

(c) That the fee for a visit by a general practitioner should be 12s. 6d., while the request from Johannesburg general practitioners that visits in the Johannesburg Municipal area should be 15s. should be considered.

(d) That in view of the fact that the Council had agreed that the words 'in so far as its rules and regulations allow' be deleted from the Preamble, a paragraph noting exclusions to the Tariff should be inserted.

(e) That a further paragraph be inserted limiting visits by general practitioners to 20 to one patient for the same complaint, after which a report should be made to the Society concerned, indicating whether further visits are necessary.

After discussion Council *agreed* with these recommendations.

Dr. Green suggested that the Groups should be informed that they could appoint a representative to be present at the final meeting to state their case to the Contract Practice Committee; this to be in addition to the information which they had supplied to the Medical Secretary at his request. Council *agreed*.

66. *Medical Aid Societies' Financial Position*: The Committee recommended that all Medical Aid Societies be asked to render their balance sheets and a statement of their reserve funds, together with itemized details of their expenditure, for examination by a qualified cost accountant to be engaged by the Association for this purpose.

After discussion it was proposed by Dr. Shapiro, seconded by Dr. Black, that the words after 'expenditure' be deleted and that the words 'and that the Committee be empowered to employ the services of a qualified cost accountant in the present negotiations and for such other purposes as they may deem necessary' be substituted.

The amended recommendation was then put to the Council and *carried*.

Dr. Green then moved the adoption of the Committee's Report as a whole. He was seconded by Mr. Sweetapple and the motion was *carried*.

SUB-COMMITTEE ON POST-GRADUATE EDUCATION AND EXAMINATION

67. *Election of a Committee to Establish a College*: The Convener, Mr. Goldschmidt, presented his Report, stating that in view of the resolutions passed at the previous meeting, the Council should now elect a committee to carry out the preliminary work of establishing a College. This was seconded by Dr. Wagner, who said that the establishment of a College would receive considerable support from the majority of the doctors in the country who were general practitioners.

Council *agreed* in principle to the election of a committee.

It was suggested that the committee should consist of twelve persons, six being resident in Cape Town and two in each of the other Provinces. The six members from Cape Town would be charged with the responsibility of meeting with the Association's lawyers and drawing up a draft Constitution.

The following names were placed before the Council and *accepted*:—

Cape: Mr. L. B. Goldschmidt, Mr. R. Lane Forsyth, Mr. M. Cole Rous, Dr. D. P. Marais, Dr. A. Landau and Dr. H. Muller.

Natal: Mr. A. G. Sweetapple and Dr. J. A. Macfadyen.

Orange Free State: Dr. R. Theron and Dr. C. D. Brink.

Transvaal: Dr. L. I. Braun and Mr. I. W. Brebner.

Dr. J. A. Bell was suggested as an alternate to Dr. Braun.

Council further *agreed* that the representatives in the Provinces should organize meetings for the discussion of the draft Constitution when it had been prepared.

68. *Representation at the Meeting Convened by the South African Medical and Dental Council*: The Committee recommended that Mr. L. B. Goldschmidt and the Medical Secretary represent the Association at the meeting convened by the Medical Council. It was proposed by Dr. Pirie, seconded by Dr. Wagner, that Dr. Geerling should be a member of the Committee.

The Medical Secretary said that he was prepared to withdraw in favour of Dr. Geerling. Council *accepted* this.

(Council adjourned at 6.20 p.m. and resumed at 8.25 p.m.)

HEALTH SERVICES

69. *Cape*: The President reported on behalf of the Augmented Executive Committee for the Cape and referred to a written report which had been circulated with the Annexures to the Agenda. Council *agreed* that this Report be *noted*.

The President then went on to speak of the appointments to be made at the Groote Schuur Hospital and after a résumé of the position he asked that the principle accepted by the Association in the Transvaal should be reiterated, i.e. that as many medical practitioners as possible should be given hospital connexions, not only in their own interests but in the interests of the public. Council *agreed*.

The President then asked for expressions of opinion from the Transvaal members of the Council.

In reply it was stated that the position in the Transvaal hospitals was unsatisfactory and there was a tendency to consider doing away with full-time appointments and making more part-time appointments as it was found that men occupying full-time appointments did not stay long in their positions and they tended to leave to take up private practice. The matter was being considered by the Transvaal Hospitals Advisory Council and also the Administration.

70. *Honorarium*: Dr. Joubert stated that the Transkei Branch was concerned about the amount of the increased honorarium, in that while it had been basically increased to double the amount per bed a ceiling had been fixed at 100 guineas. In hospitals where the beddage was predominantly for Native patients and the number of honoraries was small this amount would be out of proportion to the work done.

Dr. Schaffer agreed that it was better to accept a smaller amount and remain in the position of an honorary practitioner. He was supported by Dr. Shapiro who stated that many practitioners in the Transvaal wished to go back to the honorary system in that Province. Council *agreed*.

71. *X-Ray Services in the Cape*: A letter from the Cape Eastern Branch was submitted together with a copy of a letter addressed by the Director of Hospital Services to the Uitenhage Hospital.

Dr. Britten spoke on the position found in Grahamstown. It was proposed by Dr. Schaffer, seconded by Dr. Joubert and *resolved nem. con.* that in the opinion of the Council services rendered by a hospital to a patient for which fees are charged should be paid for by the patient to the hospital. Fees should not be collected from the doctor who had referred the patient.

72. *Appointment to Central Hospitals Committee*: The President reported that the vacancy had been filled by postal ballot and that Dr. F. R. Luke had been appointed. *Noted*.

73. *Transvaal*: A written report by the Chairman of the Augmented Executive Committee for the Transvaal was submitted and *noted*.

Dr. Struthers then reported on the establishment of a Trust Fund in connexion with specialist services. He was supported by Dr. Shapiro who stated that the Augmented Executive Committee was not able to work out any formula which should control such a Trust Fund. He considered that they should attempt to do so and place their recommendations before the Council at a future meeting. Council *agreed*.

It was proposed by Dr. Turton, seconded by Dr. Meltzer and *resolved* that Council reaffirm its previous resolution that almonizing of out-patients in the Transvaal hospitals should take place.

Dr. Meltzer asked for information as to whether the

Transvaal Provincial Administration would re-introduce the means test, as it seemed the only solution to many difficulties.

74. *Name Boards for Medical Staff Members*: A letter from the Superintendent of the Boksburg-Benoni Hospital was submitted.

The Medical Secretary stated that this matter had been referred to the Chairman of the Augmented Executive Committee for the Transvaal, but no reply had been received.

Dr. Meltzer stated that the Committee had agreed that the matter should be left to each local area for decision. Council *concurred*.

75. *Orange Free State*: The Chairman of the Executive Committee in the Orange Free State reported that no major problems had arisen since their agreement with the Provincial authorities. Council *noted* this *with acclamation*.

76. *Natal*: Mr. Sweetapple presented his Report as Chairman of the Augmented Executive Committee for Natal. He stated that no major developments had taken place in the Province other than the appointment of a Commission of Inquiry into Hospital Services. The Commission was proceeding with the taking of evidence. *Noted*.

NOTICES OF MOTION

77. *Presidency of the Association*: The Medical Secretary reported that the proposed amendments to the By-Laws had been submitted to the Branches and he reported on the replies which had been received.

The proposed amendments were put to the vote and were *carried nem. con.* They are as follows:—

'In By-Law 51 (a) change "President" and "Vice-President" to read "Chairman" and "Vice-Chairman".

Consequent on this alteration, make similar alterations to By-Laws 42, 44, 49, 55, 56, 57, 60, 61; to the Rules applicable to the Secretary of Council—5, 6 and 8, and the Rules applicable to the Treasurer of the Council—4 and 5.

In addition, insert the word "President" in By-Laws 55, 57 and 60, and add to By-Law 62 (a) the words "and elect annually the President and President-elect/Vice-President of the Association".

Finally, in By-Law 29 delete the words "of the Council" from the first and the third lines.'

78. *General Practitioners' Group*: The Medical Secretary reported that the proposed amendments to By-Law 21 had been put before the Branches and he reported on the opinions received.

The matter was put to the vote and *carried*, so that By-Law 21 now reads as follows:—

'21. Special Groups of members having a distinctive professional interest may petition the Council for recognition of such Special Groups. The membership of such a Special Group may not, at any time, be less than 11 (eleven) members.'

79. *Capitation Fee and the Payment of Subscriptions*: The Medical Secretary stated that notices of motion to amend By-Laws 10 (a) and (b) and 62 (b) were received at the last meeting of Council.

The proposed amendments were read and, on being put to the vote, were *carried nem. con.* In terms of By-Law 70, they will now be referred to the Branches for opinion.

HONOURS

80. *Emeritus Membership*:

(a) Prof. A. Pijper: The Medical Secretary read a letter from the Northern Transvaal Branch in which it was recommended that Prof. A. Pijper be made an emeritus member of the Association.

The President spoke in support of this recommendation, stating that Prof. Pijper was one of the oldest members of the Association and had been an extremely hard worker for many years as a member of the Federal Council and of the South African Medical and Dental Council.

On being put to the vote the recommendation was *carried nem. con.*

(b) Dr. F. H. Dommisse: The Medical Secretary read a recommendation from the Cape Western Branch together with a citation stating the services which Dr. Dommisse had rendered to the Association.

On being put to the vote the recommendation was *carried nem. con.*

MATTERS REFERRED TO OR BY THE SOUTH AFRICAN MEDICAL AND DENTAL COUNCIL

81. *Assessment Committees*: The Medical Secretary reported that he had obtained tariffs of customary fees from all the Branches except the Transkei Branch. These tariffs had been sent to the Registrar of the South African Medical and Dental Council in terms of the Federal Council's instructions. *Noted*.

Dr. Joubert stated that the tariff of customary fees in the Transkei Branch was very near completion and would be forwarded to the Head Office as soon as possible. *Noted*.

MATTERS REFERRED TO OR BY BRANCHES

82. *Status of General Practitioners*: The Medical Secretary reported on the replies which had been received from the Branches, many of which were lengthy memoranda. He stated that the Executive Committee recommended that a sub-committee be appointed to consider the reports and suggestions put forward by the Branches and that the sub-committee report back to the next meeting of the Council. Council *agreed* that this be done.

The President suggested that Dr. Struthers and Dr. Grundlingh be asked to form a committee with power to co-opt and that they report back to the next meeting of Council. Council *agreed*.

83. *Powers of Hospital Boards*: A letter from the Border Branch was submitted, in which it was requested that Federal Council should press for more power to be given to Hospital Boards. After some discussion Council *agreed* that the letter be *noted*.

84. *Representation on the Transvaal Hospitals Advisory Council*: A letter from the East Rand Branch was submitted, in which it was again requested that this Branch should have representation on the Advisory Council.

The President reminded the Council that a resolution had already been taken on this subject and the matter had been referred to the Provincial Administration. The present position was that two representatives were appointed by the Federal Council itself which had ruled that one should come from the Northern Transvaal Branch area and the other from the Southern Transvaal and the East Rand Branch areas.

Some discussion followed, during which the Medical Secretary explained the procedure which was followed in making such appointments.

Dr. Meltzer stated that in the circumstances he would withdraw the correspondence and accept the previous resolution of Council. *Noted*.

85. *Practice in Native Urban Areas*: A letter from the East Rand Branch was submitted.

It was proposed by Dr. Meltzer, seconded by Dr. Joubert and resolved that this Council objects to the principle of selecting medical practitioners who shall have access to or be permitted to establish consulting rooms in Native townships and recommends that representations be made to have the position corrected so as to allow all medical practitioners having the necessary access, if need be by amendment of the Native Urban Areas Act.

86. *Amendment to the Rules of the East Rand Branch*: A letter from the East Rand Branch was submitted, in which it was requested that the Municipal areas of Alberton and Edenvale be included in the East Rand Branch area.

Dr. Meltzer explained that these were two new Municipalities established in an area which was already served by the Branch. Council *agreed*.

Dr. Meltzer then withdrew the second recommendation of his Branch which dealt with annual subscriptions, as the President pointed out that this was not a matter for the Federal Council. *Noted*.

87. *Appointment of Medical Practitioners to Hospital Boards*: A letter from the East Rand Branch was submitted.

The Medical Secretary stated that the Executive Committee recommended that this matter be referred to the Augmented Executive Committee for the Transvaal. Council *agreed*.

88. *Anaesthesia in Midwifery Cases*: A letter from the Northern Transvaal Branch was submitted.

The Medical Secretary stated that the Executive Committee recommended that this matter should be included in the representations which were to be made to the Minister of Health regarding nursing services.

After short discussion Council *agreed* to the recommendation of the Executive Committee.

89. *Contributions under the Workmen's Compensation Act and Unemployment Insurance Fund*: A letter from the Northern Transvaal Branch was submitted.

The President reported that representations had already been made, with no result.

Council *agreed* that the letter be *noted*.

90. *Tariff of Refunds—Government Patients*: A letter from the Orange Free State and Basutoland Branch was submitted.

The President stated that this matter had already been dealt with by a deputation to the previous Minister of Health.

The Medical Secretary stated that the Executive Committee recommended that the matter be again placed before the Minister of Health for clarification.

It was proposed by Dr. de Villiers, seconded by Dr. Grant-Whyte and *resolved* that the recommendation of the Executive Committee be accepted.

Council further *agreed* that the Parliamentary Committee constitute the deputation to the Minister of Health.

91. *Rules Relating to the Registration of Specialists*: A letter from the Southern Transvaal Branch was submitted, reporting on resolutions passed by a meeting of practitioners in that area.

The Medical Secretary stated that this had been circulated to the Branches for opinion. He reported on the opinions of the Branches.

Council *agreed* that the matter be *noted*.

92. *Specialists and Administrative Work*: A letter from the Southern Transvaal Branch was submitted.

Dr. Broomberg stated that this was a most important matter and that a ruling should be sought from the South African Medical and Dental Council.

Dr. Bell proposed that the matter be postponed for discussion at a later session. Council *agreed*.

93. *Medical Benefit Societies as Limited Liability Companies*: A letter from the Southern Transvaal Branch was submitted, and Council *agreed* that this item be *noted*.

94. *Absentee Membership*: Correspondence with the Southern Transvaal Branch was submitted.

The Medical Secretary reported that a number of members proceeding overseas for study and other purposes resigned their membership and often were lost to the Association. He stated that the Executive Committee recommended that those members who would be proceeding overseas for at least twelve months should become unattached members of the Association for the period of their absence. They would thus be charged a uniform subscription of £1 11s. 6d. per annum.

Council *agreed* to the recommendation of the Executive Committee.

(*Council adjourned at 11.35 p.m.*)

SATURDAY, 14 APRIL

(*The meeting commenced at 9.20 a.m.*)

MATTERS REFERRED TO OR BY GROUPS

95. *Legal Representation at Inquests*: A letter from the Anaesthetists' Group was submitted. This letter was amplified by Dr. Grant-Whyte who moved, seconded by Dr. Geerling, that this matter be taken up with the Atlas Assurance Company. Council *agreed*.

96. *Fees for Workmen's Compensation Act and Pension Cases*: A letter from the Anaesthetists' Group was submitted. It was proposed by Dr. Grant-Whyte that this be noted. Council *agreed*.

97. *Salary Scales—Union Health Department*: A letter from the Medical Officers of Health Group was submitted, in which revised salary scales for senior personnel of the Union Health Department were suggested.

It was proposed by Dr. de Villiers, seconded by Dr. Gie and *resolved* that this suggested revision of scales should be recommended to the Minister of Health by the Council.

98. *Revision of Constitution of the Neuro-Psychiatrists' Group*: A letter from the Neuro-Psychiatric Group was submitted, in which it was requested that the Council approve the change of name of the Group to that of the 'Neuro-Psychiatric and Neuro-Surgical Group of South Africa' and that it agree to all other consequential changes in its Constitution. Council *agreed*.

99. *Branch Radiological Practices*: A letter from the Radiological Group was submitted, in which it was indicated that the Group disapproved the establishment of branch radiological practices.

Dr. Geerling stated that he understood that the South African Medical and Dental Council disapproved of this form of practice.

Dr. Struthers said that the Northern Transvaal Branch supported this disapproval. He proposed that Council associate itself with the opinion of the Group. He was seconded by Dr. Geerling and Council *agreed*.

100. *Fees Paid to Assistants at Operations*: A letter from the Surgeon's Group was submitted, in which it was suggested that the Federal Council request the South African Medical and Dental Council to formulate an ethical rule laying down the fees payable to assistants at operations at 10% of the surgeon's fee.

It was proposed by Dr. Green, seconded by Dr. du Toit and *resolved nem. con.* that the matter be referred back to the Association of Surgeons of South Africa for full information and reasons as to why the change should be made.

MATTERS REFERRED TO OR BY AFFILIATED ASSOCIATIONS

101. *Joint Meeting*: The President stated that he did not think it would serve any useful purpose to discuss the cancellation of the Joint Meeting. The circumstances were known to all members through a statement which he had circulated and through information made available in the *Journal*.

Certain resolutions, forwarded to the Council by the Cape Western Branch, were submitted.

It was proposed by Dr. Geerling, seconded by Dr. du Toit, that they be noted and that no action be taken.

It was proposed by Dr. de Villiers, seconded by Dr. Theron and resolved that the words 'and that no action be taken' be deleted from the motion proposed by Dr. Geerling.

Dr. Geerling's motion as amended was then put to the meeting and *carried nem. con.*

It was then proposed by Dr. Broomberg, seconded by Dr. Green and *resolved nem. con.* 'that this meeting of the Federal Council of the Medical Association of South Africa expresses its deep regret and disappointment at the circumstances which gave rise to the cancellation of the Joint Meeting with the British Medical Association and trusts that it will still be possible to make satisfactory arrangements for such a meeting to be held in South Africa at some future date'.

102. *South African Medical Congress in 1951*: The President stated that with the cancellation of the Joint Meeting the Southern Transvaal Branch had invited the Association to have an ordinary South African Medical Congress in Johannesburg in December, should the Council wish the Congress to be held this year. If not, the Branch would forward a firm invitation for a Congress to be held in Johannesburg in 1952. After discussion it was proposed by Dr. Broomberg, seconded by Dr. du Toit and *resolved nem. con.* that the invitation to hold the South African Medical Congress in Johannesburg in 1952 be accepted. This was passed *with acclamation*.

103. *Financial Loss due to Cancellation of Joint Meeting*: The Medical Secretary gave details of the loss which it was expected would result following the cancellation of the Joint Meeting. It was probable that some £1,200 would have to be written off the books. He stated that Mrs. Thomas would be leaving the service of the Association and he suggested that she be paid a sum of money in lieu of notice and the leave which was due to her. In addition he suggested that the Association waive all rights to her pension policy and present this to her.

It was proposed by Dr. du Toit, seconded by Dr. Gie and *resolved nem. con.* that in view of the cancellation of the Joint Meeting the services of Mrs. Thomas (now Mrs. Kirby) be terminated forthwith but that she be paid in one sum her salary at present rates up to the end of June, this to include payment for such leave as had accrued to her. It was further *resolved* that her Superannuation Fund policy be ceded to her

as a free gift, the premium being paid up to 31 December 1951.

104. *Rules of Future Congresses*: The President stated that it was becoming increasingly difficult to hold a Congress each year and in view of the many changes which were taking place he suggested that a committee be appointed to revise the rules regarding the holding of Congresses.

After a short discussion it was proposed by Dr. du Toit, seconded by Dr. Geerling and *resolved* that the matter of the revision of the Rules of Congress be referred to the Head Office and Journal Committee for consideration.

105. *British Commonwealth Medical Conference*: The Medical Secretary reported that following the cancellation of the Joint Meeting the Secretary of the British Medical Association, who was also Secretary of the Conference, had written to say that the Council of the British Medical Association had agreed that the Conference should be cancelled also. He had added that as Honorary Secretary of the Conference he would write to the various member-associations, explaining the position to them and inviting them to agree that the next Conference should be held in India in 1952 at the invitation of the Indian Medical Association. *Noted.*

The President said that the question now was whether we as a member of the British Commonwealth Medical Council would agree to the invitation for a meeting to take place in 1952 being held in India. Council *agreed* that the invitation be accepted.

106. *Presentation of a Medical Film by the British Medical Association*: The Medical Secretary reported that the Council of the British Medical Association had offered to present to the Association a copy of the colour and sound film 'The Treatment of Infections of the Hand' made under the auspices of the British Medical Association by the courtesy of Messrs. Glaxo (Pty.) Ltd. The question of the formalities regarding the importing of the film was being investigated.

Council *agreed* that the presentation of the film be acknowledged with gratitude.

MATTERS REFERRED TO OR BY THE WORLD MEDICAL ASSOCIATION

107. *Application for Membership of the World Medical Association from the Japan Medical Association and the Western German Medical Association*: Letters and memoranda from the World Medical Association, together with a memorandum from the Israel Medical Association, were submitted.

It was proposed by Dr. Geerling, seconded by Mr. Sweetapple, that there should be no objection to these Associations becoming members of the World Medical Association.

An amendment was proposed by Dr. Shapiro, seconded by Dr. Collins, as follows:—'That the World Medical Association be informed that the Medical Association of South Africa is opposed to the granting of full membership to the Medical Associations of Western Germany and Japan at the present time but proposes that a class of associated membership be created to which these Associations may be admitted for a probationary period. This will provide an opportunity for the members of the profession of those countries to demonstrate their bona fides.'

Considerable discussion followed and on being put to the vote the amendment was *carried* by 14 votes to 11. It was then put as a substantive motion and carried with four dissentient votes.

108. *Proposed Activities of the International Bureau of Military Medicine and the Medico-Juridical Council of Monaco*: A memorandum on this subject was submitted.

Dr. de Villiers proposed that this Association should support the World Medical Association in its opposition to these activities. Council *agreed.*

109. *World Medical Association Constitution*: A memorandum was submitted and the Medical Secretary amplified this by stating that the request was that the Constitution be altered to provide that Past-Presidents of the World Medical Association shall be ex officio members of the Council and delegates to the Assemblies but without voting powers. Council *agreed.*

110. *The Declaration of Geneva*: The Medical Secretary stated that the World Medical Association had supplied him with a number of copies of this Declaration. If any members of the Council wished to have copies, either for their Branch offices or for presentation to hospitals, he would be glad to hand copies to them. *Noted.*

MISCELLANEOUS

111. *Cancer Conference to be held in July 1951*: It was proposed by Dr. Green that Dr. Charlton be appointed to represent the Association at this Conference. Council *agreed.*

112. *Medical Examination of Participants in Sport*: A letter and memorandum on this subject were submitted, in which four questions were asked.

It was proposed by Dr. Higgins, seconded by Dr. Green and *resolved nem. con.* that all four questions be answered in the affirmative.

113. *National Veld Trust—Appointment of Representatives*: The Medical Secretary reported that Dr. Schulenburg, who had represented the Association on the National Veld Trust Board, had resigned his membership on the Board. It was necessary that a member resident in the Transvaal should be appointed as representative, as most of the meetings were held in Johannesburg. Dr. J. S. du Toit was the alternate representative for such meetings as might be held in Cape Town.

It was proposed by Dr. Geerling, seconded by Mr. Goldschmidt and *resolved* that the Southern Transvaal Branch be asked to nominate a suitable person.

114. *South African Bureau of Standards*: The Medical Secretary reported that the South African Bureau of Standards had asked for representatives to serve on committees to draw up specifications for Baby Foods and for Saline Dextran. The matter had been referred to the Southern Transvaal Branch which had recommended that Dr. Seymour Heymann be appointed to the first committee and Dr. L. I. Braun to the second, each to have alternates, namely Dr. J. L. Parnell and Dr. Seymour Heymann respectively.

Council *agreed* to these nominations.

115. *Specialists and Administrative Work*: Council then reverted to further consideration of Item 92 above.

Dr. Shapiro stated that representations had been made to the Southern Transvaal Branch by the Vereeniging Division as a practitioner in the full-time employ of the Vanderbijl Park Benefit Society had been appointed to a part-time post as Superintendent of the Hospital. It was felt that the superintendent of a public hospital should be an independent person and not an employee of any organization.

After discussion it was proposed by Dr. Pirie, seconded by Dr. Geerling and *resolved nem. con.* that whenever there is any material change in the conditions of service attaching to any appointment, that post should be readvertised.

116. *Ethical Rules Concerning Benefit Societies*: Council then reverted to further discussion of this subject (see Item 9 above).

Dr. Shapiro gave various reasons why he considered such ethical rules should be laid down, stating that it would be of considerable value if an Association of Benefit Societies could be formed on the same lines as the Northern Association of Medical Aid Societies. He moved that such a rule should be formulated.

The President stated that the Council could not pass such an ethical rule unless it were in a state of emergency. According to the Association's Constitution each Branch must separately adopt such an ethical rule. *Noted.*

ANY OTHER BUSINESS

117. *National Council for the Care of Cripples*: The Medical Secretary stated that a letter had been received from the National Council for the Care of Cripples regarding the appointment of a part-time orthopaedic surgeon at East London, which the National Council was prepared to subsidise. The Executive Committee had recommended that this matter be taken as urgent.

It was proposed by Dr. Schaffer that this matter be referred to the Border Branch and that the reply of the Branch be considered by the Executive Committee. Council *agreed.*

118. *Death of Dr. de Jager*: The President stated that Dr. A. L. de Jager of Paarl, who had long been a faithful member of the Association, had passed away and he proposed

from the Chair that a message of condolence be sent to the Chairman of the Drakenstein Division of the Cape Western Branch . Council *agreed*.

119. *Date and Place of Next Meeting of Council*: The President stated that an invitation had been received to hold the next meeting of the Council in Bloemfontein.

Council *agreed* that, if possible, the meeting should be held in Bloemfontein at a time to be decided by the Executive Committee.

120. *Vote of Thanks to the President*: Dr. Broomberg rose to propose a vote of thanks to the President for the very able manner in which he had conducted the meetings of the Council during the past six years. He felt that all members of the Council deeply appreciated the courtesy which Dr. Sichel had continually shown to them and he felt that he had endeared himself not only to members of the Council but to all members of the Association with whom he had come into contact. *Acclamation.*

In replying, the President thanked Dr. Broomberg for his remarks and the Council for the spirit in which they had been received.

He went on to say that at the next meeting a new Council would have been elected and it would have to elect, in terms of the amendments to the Constitution, a Chairman of Council and a President of the Association. He stated that he would not seek re-election but that he gave his assurance that he would continue to do his share of the work of the Association to the best of his ability. He was at present the Chairman of the Head Office and Journal Committee and was willing to continue in this position if so requested. He would also be a member of the Council for the next three years.

Dr. Sichel said that he not only wished to thank members for their loyal co-operation and assistance, but he would like to take the opportunity to express his deep appreciation of the help which he had received at all times from the permanent officials of the Association, the Medical Secretary, the Editor and other members of the staff, as well as to the officials of the Branches and Divisions to whom he had become personally indebted for many acts of kindness. He stated that during his term of office striking developments and progress had been witnessed in the organization of the Association. He recalled that he had been a member of the Council for fifteen years and that in the earlier days the Federal Council meetings had occupied only part of the day, whereas now the volume of business occupied three full days and often an evening session as well. He went on further to outline the increase in permanent staff which had become necessary to carry out the affairs of the Association. In conclusion Dr. Sichel referred once more to his visit overseas, stating that he would be greatly fortified and encouraged by the knowledge that he was going with the good wishes of members of the Council and others in the Association. *Acclamation.*

(The meeting ended at 1.5 p.m.)

GRIQUALAND WEST BRANCH

MINUTES OF THE GENERAL MEETING HELD AT THE HELEN BISHOP AFTER-CARE HOME, ON 28 JUNE 1951

Dr. Tandy was in the chair and 18 members were present.

The meeting was opened by Dr. Tandy and the proceedings handed over to Dr. Bishop who, after welcoming the members to this new institution, proceeded to a demonstration of cases assisted by Mr. Minnaar.

Cases Shown: (1) Intra-articular dislocation of the hip joint, following tuberculosis of the upper part of the acetabulum (picture similar to Otto's pelvis).

(2) Healed cervical tubercle which developed a picture not unlike Sudek's atrophy of both lower limbs.

(3) Spastic diplegia, demonstrating the progress possible with physiotherapy.

Dr. Bishop then read a paper on the socio-economic aspect of the crippled child. We hope that this paper will subsequently be printed in the *Journal*. Mrs. Gallow, the teacher on the staff, discussed briefly the educational aspect of the crippled child in a home of this nature.

Finally, two films from the Institute for the Crippled and Disabled, New York, were shown and appropriately applauded. After a lavish tea, the Chairman thanked every one responsible for the success of the evening: Dr. Bishop, the staff of the After-Care Home, the matron, Mrs. Gallow and the ciné-projectionists.

REVIEWS OF BOOKS

CONVICTS AND CRIMINALITY

My Six Convicts. By D. P. Wilson. (Pp. 335. 15s.) London: Hamish Hamilton. 1951. (South Africa: Juta Co., Cape Town.)

The author, a Professor of Psychology in the United States, was sent by the U.S. Public Health Service in the early 1930's to the Fort Leavenworth Penitentiary for the purpose of investigating the connexion between drug addiction and criminality. More interesting than Dr. Wilson's findings on this aspect of criminality is the subject matter of the remaining nine-tenths of his book. Here he tells vividly the story of his 3-year stay in the prison, giving the reader insight into prison life from the standpoint of the inmates and including many humorous incidents resulting from their manoeuvres.

A true understanding of the psychological problems of the convicts such as one obtains glimpses of in the stories of the lives of these six men, does much towards furthering the attitude of all who read it to the need for more humanitarian penal laws.

The account of the manner in which the inmates maintained contact with the outside world is intriguing. As far as this smuggling was concerned, they managed to include even radiograms and living females in their trading.

Dr. Wilson's achievement in employing six of the convicts as psychological assistants for his staff, the manner in which he trained them, and the results they achieved as a team, is indeed a great personal triumph.

To the layman this book will prove fascinating; to the psychologist, the psychiatrist and others concerned in any way with this type of work, informative; and to all it can be highly recommended as interesting and very entertaining reading matter.

ORTHOPAEDICS AND TRAUMATIC SURGERY: 1950

The 1950 Year Book of Orthopedics and Traumatic Surgery (November 1949—November 1950). Edited by Edward L. Compere, M.D., F.A.C.S. (Pp. 388 with 264 illustrations. $5.00.) Chicago: Year Book Publishers, Inc.

Contents: 1. Progress in Orthopedic Surgery, 1940-50. 2. Poliomyelitis. 3. Congenital Deformities. 4. Embryology, Physiology and Anatomy of the Skeletal System. 5. The Epiphyses. 6. Osteomyelitis and other Infections. 7. Tumors, Cysts and Fibrodysplasia. 8. Arthritis and Rheumatism. 9. Fractures. 10. The Spine and Pelvis. 11. The Neck, Shoulder and Arm. 12. The Hand. 13. The Hip, Leg and Knee. 14. The Foot and Ankle. 15. Amputations and Prosthesis. 16. Surgical Technic. 17. Instruments, Appliances and Bone Banks. 18. Miscellaneous.

This issue maintains the previous high standard set by the series. The preface is of more than ordinary interest for its brief but stimulating review of the most important advances in orthopaedics during the past 10 years. The Editor is to be congratulated on his comprehensive albeit careful selection and preparation of the abstracts from American, British and European literature. All are very readable and succinct, and there are numerous first-class roentgenograms and other illustrations. The editorial comments interspersed among the abstracts, are gems of sound advice.

This little volume is strongly recommended as an excellent review of orthopaedics for 1950, and as a reference and means of access to important articles which are not obtainable in the original.

INCONTINENCE IN THE ELDERLY

Incontinence in Old People. By John C. Brocklehurst, M.D. With a Foreword by Stanley Alstead, M.D., F.R.C.P. (Pp. 191 + xiii with 62 figures. 30s.) Edinburgh: E. & S. Livingstone Ltd. 1951.

Contents: Part I: Review of Previous Literature. 1. The Anatomy of the Bladder. 2. Afferent Nerve Supply and Bladder Sensation. 3. Efferent Nerve Supply to the Bladder. 4. Bladder Centres in the Central Nervous System. 5. The Mechanism of Micturition. 6. Automatic Micturition. 7. The Neurogenic Bladder. 8. The Urethral Sphincters. 9. Senile Incontinence. 10. The Action of Adrenergic Drugs on the Bladder. 11. Other Methods of Treatment of Urinary Incontinence. 12. The Physiology of the Rectum. 13. Abnormal Rectal Mechanism. 14. Drug Actions on the Colon. Part II: The Aetiology of Incontinence in Old People. 15. Introduction. 16. A Study of the Bladder, Rectum, and Anal Sphincter in Senile Incontinent Patients. 17. Cystometrographic Results. 18. Rectal Findings. 19. The Anal Sphincter. 20. Survey of Incontinent Patients in Five Glasgow Hospitals. 21. Discussion of the First Survey. 22. Survey of One Hundred Senile Incontinent Patients (I) History. 23. Survey of One Hundred Senile Incontinent Patients (II) Physical Examination. 24. The Aetiology of Incontinence—Discussions and Conclusions. Part III: The Management of Incontinence in Old People. 25. Introduction. 26. Rehabilitation. 27. The Use of Drugs. 28. Other Methods of Management. 29. A Special Bed for Incontinent Patients. 30 and 31. Plaster Bed. 32. The Wooden Bed. 33. Conclusion. Index

Incontinence has always been with us and will so continue, increasing as the age of the population increases.

The purpose of this monograph is an attempt to explain the causes and to suggest a cure where possible: failing a cure, a method whereby adequate nursing and comfort can be provided to the patient with the least waste of nursing hours and at minimum cost. When it is realized that an overall survey of general hospitals in Glasgow has shown a 10% incontinence rate among patients and that an incontinent patient requires five bed changes daily, each requiring up to one hour of a nurse's time, the importance of this work is apparent.

The facts are painstakingly compiled with adequate tracings, tables and statistics; the author's conclusions are stated carefully and without dogmatism.

Drugs appear to play no part in treatment but ambulation, wherever possible, is of primary importance. It seems reasonable to suppose that the special beds he recommends for the bed-ridden will become common in all hospitals in the near future.

The attitude to these cases in the past has been one of *laissez-faire*; the author is to be congratulated on his very successful attempt to understand and deal with this very real problem.

The book is well produced, the format good and the illustrations more than adequate; its importance to all whose work it is to care for the aged cannot be over-emphasized.

THE DIABETIC'S HANDBOOK

Good Health with Diabetes—A Patient's Handbook. (Second Edition.) By Ian Murray, M.D., F.R.F.P.S.G., F.R.C.P.E. and Margaret B. Muir, S.R.N. (Pp. 44 + iv, with 2 illustrations. 2s.) Edinburgh: E. & S. Livingstone Limited, 1951.

Contents: 1. Introduction. 2. The Diet. 3. Specimen Menus. 4. 'Equivalent Foods'. 5. Emergency Diet. 6. Taking Insulin. 7. Testing Urine. 8. Emergencies and how to deal with them—A. Insulin Reactions. B. In Case of Illness. C. What to do for Sore Feet. D. Diabetic Coma. E. No Insulin!

The medical practitioner will find this a useful handbook to which to refer the diabetic patient. It emphasizes the healthy and desirable principle that the daily intake of carbohydrates should be constant.

This pamphlet explains quite simply what the patient needs to know in order to understand his dietary requirements.

The inclusion of a weight-reducing diet for the obese diabetic is very useful. The menus and 'equivalent foods' will do much to make the diet of the diabetic variable and interesting.

PASSING EVENTS

THE DOCTOR AND HIS INCOME TAX

An authoritative and comprehensive guide to the medical practitioner's income tax assessment has been prepared on behalf of the Medical Association of South Africa. The full text of this article will be available in the next issue of the *Journal*.

AN EMERGENCY TELEPHONE SERVICE FOR DOCTORS IN CAPE TOWN

As our colleagues will note from an advertisement elsewhere in this issue, an Emergency Telephone Service has been inaugurated in Cape Town and comes into operation immediately.

The Service has been instituted as the result of the initiative displayed by Mr. A. G. Lunnis, who established a similar Service some three years ago in Durban where it has proved extremely useful if not indispensable to medical practitioners there. It is operating very successfully in Johannesburg and some of our colleagues in Cape Town have already joined the Cape Town Service.

The Emergency Telephone Service will cover all medical practitioners living and practising not only in Cape Town but also in the Northern and Southern suburbs.

The Service enables members of the profession to enjoy leisure hours at night and during weekends and holidays, secure in the knowledge that messages to and from patients will be recorded accurately and passed on immediately.

The Service will also be in close contact with all hospitals and nursing homes for any emergency and, when required to do so, will arrange for ambulances.

CORRESPONDENCE

CONGENITAL MEGACOLON AND HIRSCHSPRUNG'S DISEASE

To the Editor: It was with much interest that I read Mr. Katz' article on *Congenital Megacolon Treated By Colectomy* published in the *Journal* of 23 June which I received to-day. It has prompted me to offer a few words of constructive criticism.

I notice that Mr. Katz uses the term 'congenital megacolon' as a synonym for 'Hirschsprung's disease'. May I point out that the outstanding work of Bodian and others at the Hospital for Sick Children, Great Ormond Street has revealed that megacolon without organic obstruction covers two big groups of conditions? These are Hirschsprung's disease proper and so-called idiopathic megacolon.

Hirschsprung's disease is a congenital malformation of the bowel wall characterized by the absence of intramural ganglion cells and dysplasia of autonomic nerve bundles. It affects a segment of bowel, which is almost invariably the rectum and rectosigmoid. It produces characteristic symptoms which are often present from birth and presents typical radiological appearances on barium enema examination. Both on the X-rays and at operation the affected segment appears narrow or 'normal', while the normal bowel above is hypertrophied and dilated. The work of Swenson *et al.* at Boston and of Bodian, Stephens *et al.* at Great Ormond Street has given conclusive proof that the only effective treatment of the malady is by excision of the apparently normal narrow segment, i.e. by rectosigmoidectomy. Many of the babies require a preliminary colostomy during the first few months of life and Swenson has performed the major procedure in infants aged three months and less. At Great Ormond Street rectosigmoidectomy is usually postponed until the child is 12 to 18 months old and they have all stood the operations very well indeed. Furthermore, it has been shown that any improvement which apparently followed sympathectomy, colectomy, etc. done in the past was not due to the operation but to the attendant 'medical' care such as regular bowel washouts, etc. All cases of true Hirschsprung 'recur' unless treated along the lines indicated above.

Idiopathic megacolon, on the other hand, is much more

common and is a benign condition without structural changes in the bowel wall apart from secondary hypertrophy and dilatation. It is simply chronic constipation with secondary faecal impaction, and Denis Browne describes it very aptly as colonic inertia. Characteristically hard faecal masses are felt on abdominal examination. Its treatment is medical and not surgical. In the past many of these cases have erroneously been regarded as Hirschsprung's disease and treated by sympathectomy, etc. As in the cases suffering from the more serious disorder any improvement that followed was entirely due to the attendant bowel washouts, etc.

I cannot here enter into a discourse on the clinical features, differential diagnosis and treatment of these conditions. Ever since 1948 Swenson, Bodian, Stephens, Denis Browne, etc. have published excellent articles on the subject and a brief review of their work appeared in this very *Journal* 18 months ago (Thompson and Kaye, 4 February 1950). This work is regarded as one of the great advances in paediatric surgery in recent years and two leading articles in the *Lancet* have dealt with the subject during the past 18 months.

I would like to ask Mr. Katz in which category he classifies his case. His diagram illustrates no more than a simple volvulus of the sigmoid with dilatation of the bowel above as far as the splenic flexure and the history suggests previous recurrent attacks which untwisted spontaneously. No criticism is being levelled against the surgical procedure adopted in this case and Mr. Katz is to be congratulated on the successful outcome. But why claim that a case of Hirschsprung's disease has been successfully treated by colectomy? Admittedly sigmoid volvulus is uncommon during childhood but it does occur and even during the neonatal period.

It would appear that the patient suffered from a moderate degree of 'colonic inertia' complicated by recurrent attacks of volvulus of the sigmoid. In this connexion it is interesting to note that attempts at closing the colostomy failed on two occasions, suggesting that there was still a certain amount of 'obstruction' distally. It would thus be illuminating to know how much 'medical treatment' the boy received in the form of post-operative aperients, enemas, encouragement to have regular bowel habits, etc., for these are the very measures which will cure the lazy bowel of the chronically constipated child.

J. H. Louw,
Nuffield Scholar.
The Hospital for Sick Children,
Great Ormond Street,
London, W.C.1.
16 July 1951.

INTERFERENCE WITH DEAD BODIES

To the Editor: The legal propositions advanced in the article of 2 June last entitled 'The Medico-Legal Aspects of Interference with Dead Bodies' are somewhat more controversial than would appear from the article concerned. Indeed, in the opinion of the present writer, there is more to be said against these views than for them.

The question divides itself into three topics, namely:—

1. Offences under the Anatomy Act;
2. The common law offence of despoiling a dead body;
3. Civil claims by relatives of the deceased.

The position under the Anatomy Act gives rise to no difficulty. The matter here dealt with is dissection for teaching purposes, and such dissection may not be practised except under the conditions laid down in the Act.

At common law, it is clear that an offence of violating a grave exists. This offence is committed by anyone who interferes with the tombstone, disinters the body, or otherwise damages the grave. The eminent Dutch Writer on criminal law, Matthaeus, does not deal at all with a separate offence of violating a corpse, but simply regards interference with the corpse as an aggravating factor in the violation of a grave. He ends his discussion of this crime with the following illuminating passage[1]: 'Several Authorities write that a plea of public benefit will avail to meet a charge of violation of graves where doctors or students exhume a corpse for the purpose of studying anatomy. This view cannot be approved. Public benefit can be satisfied by the dissection of the corpses of condemned criminals and there is no necessity to commit the sacrilege of invading dead men's graves.'

From this it appears, firstly, that dissection of certain corpses was legal before the Anatomy Act and, secondly, that doctors who, in excess of zeal, pillaged graveyards for their specimens would be charged with violation of graves, not of corpses. How can this be squared with the proposition that all interference with corpses is a criminal offence?

The crime of 'despoiling' a corpse is discussed by Pothier,[2] and Carpzovius.[3] It is clear that 'despoiling' (Latin *spoliare*) means stealing clothes, ornaments, money, etc., from the corpse. The only author who speaks of 'violating' a corpse is Carpzovius[4] who in discussing the penalties laid down in a certain edict of the Elector of Saxony (not applicable to South Africa), says that these penalties apply only to those who 'despoil *and* violate' corpses. This solitary phrase is most inadequate authority for the proposition that there is in South African law a crime of despoiling *or* violating corpses.

The only South African case in which the matter has been considered is that of *Rex* vs *Kunene and Mazibuko*[5] in which two natives excised and removed parts of a corpse, apparently for the purpose of making 'muti' with the parts. This was not a decision of the Supreme Court, and has not been fully reported. Thus it is of little weight as a legal authority. In any case, there is a very obvious difference between the removal and destruction of parts of a corpse for purposes of black magic, and the conduct of a *bona fide* post-mortem examination in which all organs are replaced at the conclusion.

It is submitted, therefore, that there is no substantial authority in South African Law for the proposition that it is a crime to undertake a properly conducted post-mortem examination in cases where this is not authorized by statute.

CIVIL CLAIMS

The relatives' civil claim, if any, can, of course, be waived by them. Thus, if the view expressed above as to the criminal law be correct, the consent of the relatives will be a complete safeguard to a practitioner performing a post-mortem examination.

It is submitted, however, that the relatives have no claim for damages even where their consent has not been obtained. The American law on the point is irrelevant, since there are wide divergences between South African and American law. Scottish law is much closer to South African law, and the Scottish cases on the point merit some attention.

There are three of these cases, namely, *Pollok* vs *Workman*,[6] *Conway* vs *Dalziel*[7] and *Hughes* vs *Robertson*.[8] In all these cases, the plaintiffs were put out of Court at the outset on procedural grounds, owing to the formidable difficulties of formulating the correct procedure for bringing such an unusual claim. Thus the legal issues involved were never authoritatively decided. The opinion quoted in the article of 2 June was expressed by a single judge during preliminary proceedings, and was never concurred in by the full Court.

It must furthermore be noted that special, aggravating circumstances were present in all the cases under discussion. In *Pollok*'s and *Conway*'s cases, the deceased had died at home, and it was alleged that the doctors concerned (who had not attended the deceased during his lifetime) had entered the house where the body was lying without permission, at the instance of an interested insurance company, in order to carry out a post-mortem examination. In *Conway*'s case it was furthermore alleged that parts of the body had been removed, and not replaced, and in *Hughes*' case it was alleged that the doctor was in the employ of an interested party, and had deliberately made away with certain organs which provided evidence of the cause of death.

Even in the law of Scotland, therefore, the proposition that relatives can claim damages where a *bona fide* and properly conducted post-mortem examination is held by the hospital in which the deceased died, is a doubtful one. In South African law there is no authority at all for such a proposition. On

1. *De Criminibus*, 47.6.2. (the writer's translation).
2. Ad Pandectas, 47.12.3.
3. 2.83.53-65.
4. 2.83.65.
5. 1918 Natal N.H. J/S 321.
6. 1900. 2 F. 354.
7. 1901. 3 F. 918.
8. 1913. S.C. 394.

general principles, the relatives could only claim damages if they could show that an injury had been done to themselves. This injury would have to consist either of pecuniary loss or of an 'aggression upon the person, dignity or reputation of the plaintiff'.[9] It is submitted that a post-mortem examination could not amount to such an 'aggression' unless the body was left in a mutilated condition, or detained for a substantial time so as to prevent the relatives from proceeding with funeral arrangements, or interfered with after having been laid out or prepared for burial.

In the old Roman Law, it was possible in some circumstances for the heir of a deceased person to claim damages for a wrong (e.g. defamation) done to the deceased after his death. This provision is now obsolete,[10] and the general rule is as stated above, that the plaintiff must prove injury to himself.

It is submitted, therefore, that post-mortem examinations may be conducted with impunity provided that they are done expeditiously and with all due precautions to avoid mutilation.

A. P. O'Dowd, B.A., LL.B.

Johannesburg.
16 July 1951.

9. McKerron's *Law of Delict*, p. 64.
10. See *Spendiff* vs *East London Daily Dispatch*, 1929 E.D.L. 113.

CYBERNETICS

To the Editor: May I take exception to the dogmatic condemnation of the 'so-called science of cybernetics', made by Dr. Taylor of the Department of Psychology, U.C.T., in your issue of 21 July.

Dr. Taylor begins his tirade by stating: 'The so-called science of cybernetics starts from the observation that electronic calculating machines display some of the characteristics of the human mental process.' This is incorrect. The application of cybernetics to C.N.S. function, though dramatic, is only incidental. The science would exist even were this aspect ignored. 'And,' he continues, 'postulates that the central nervous system functions in the same way as these machines, although on a grander and more complicated scale'. Grossly absurd. All that is suggested is that there is much in common. Feed-back mechanisms were long known to exist in the body, although not labelled as such.

I will not deal with Dr. Taylor's objections to the attempted cybernetic explanation of memory mechanisms, other than point out that most of his arguments were specifically considered in the book *Cybernetics*, written by Prof. Wiener, one of the founders of the new science.

At this point Dr. Taylor makes so serious a blunder as to raise considerable doubt as to the value of his criticism. 'Functional disorders of the brain are frequently cured by passing an electric current through the brain, so why not pass a high tension current through Eniac when it turns temperamental?' The guardians of Eniac would undoubtedly suspect the sanity of anyone making such a suggestion, and yet the reverse proposal, that methods of treatment suitable to Eniac should be tried on man, has been seriously put forward by a writer who presumably was judged to be sane at the time when his book was accepted for publication.' Thus, Dr. Taylor. Whatever the merits of cybernetics, Prof. Wiener, sane or insane, is a recognized authority on electronic computing machines; he states that in a 'temperamental' machine 'we subject the machine to an abnormally large electrical impulse in the hope that we may reach the inaccessible part and throw it into a position where the false cycle of its activities will be interrupted'. It was precisely this similarity between mind and machine which, seized upon by the lay press, gave rise to the popular misconception so well exemplified in Dr. Taylor's opening remarks.

Consideration of the above two paragraphs makes it clear that Dr. Taylor has not learnt of the subject at its source. Consideration of his opening remarks makes it equally clear that he has barely read the Editorial to which he took such strong objection. From where, then, has Dr. Taylor derived his 'knowledge' of the subject?

Descending from the level of the great unread, to that of the merely abusive, Dr. Taylor continues: 'The secrets of the brain will never be revealed to scientific charlatans; they will finally emerge only as a result of the joint labours of workers in several related fields, ranging from neurophysiology at one end to behaviour science at the other.' In 1946 a meeting was held at the Macy Institute, New York, and a formal group of cyberneticists was brought into existence. The group contained physiologists, engineers, mathematicians, psychologists, anthropologists and sociologists. These scientists represented institutions such as the Rockefeller Institute of New York, the Universities of Pennsylvania and Chicago, and the Massachusetts Institute of Technology. Professor Bartlett of the Psychological Laboratory, Cambridge, England, has expressed his friendly interest. Professor Wiener quotes Professor J. B. S. Haldane as regarding cybernetics one of the most urgent problems on the agenda of science and scientific philosophy. Yet Dr. Taylor has no hesitation in describing cybernetics as 'a cheap and shortsighted attempt . . .' made by 'scientific charlatans'.

In conclusion Dr. Taylor states: 'Cybernetics is not a science at all, but a cheap and shortsighted attempt to explain the workings of the brain, *without submitting to the gruelling discipline that any genuine science imposes on its students*.' May I suggest that Dr. Taylor himself submit to this discipline.

L. C. Isaacson, B.Sc.

5 Valdora House, Grove Avenue,
Claremont, Cape Town.
23 July 1951.

RIFT VALLEY FEVER IN SOUTH AFRICA

To the Editor: This letter is written for publication in your *Journal*, at the request of the Union Health Department, to call immediate attention to the occurrence of human cases of Rift Valley fever in South Africa.

Rift Valley fever or enzootic hepatitis is primarily a disease of sheep and cattle and apparently is spread amongst them by mosquitoes. It is caused by a virus which has a selective affinity for the parenchymal cells of the liver. Pathologically it is characterized by extensive necrosis of the liver. The hepatic cells, on microscopic examination, show a characteristic eosinophilic degeneraton of the cytoplasm and eosinophilic intranuclear inclusion bodies. The disease causes a high mortality amongst newborn lambs. Pregnant ewes and cows nearly all abort and a large proportion may die. Human beings may be infected during an epizootic in domestic animals. The infection is usually acquired whilst handling the viscera or meat of the carcasses of animals dead from the disease.

The illness is clinically characterized by an incubation period of four to six days, by a sudden onset, with pain and stiffness of the limbs, backache, photophobia, severe headache, often delirium, nausea, occasionally vomiting, and abdominal discomfort, and by fever lasting up to one week, often and characteristically showing a biphasic temperature chart. Only one fatal human case is on record. Recovery is usually rapid and complete. However, some patients develop scotoma or other defects of vision, associated with a white exudate in the retina soon after the acute illness.

Until this year, when an extensive epidemic occurred in the autumn, Rift Valley fever was not known in South Africa. So far the disease has spread through the pan-veld region of the Western Orange Free State and North-Western Cape Province, and the South-Western Transvaal. From this area it has spread along the Vaal River basin as far east as the Standerton District. The infected area may be more extensive than this and medical practitioners are requested to look for cases, and especially for cases in which defects of vision develop soon after an acute febrile illness. If medical practitioners see such cases and have reason to suspect that Rift Valley fever may play a part in their aetiology, a specimen of blood from the patient should be sent to this Institute for the complement fixation test to confirm the diagnosis. By doing so they will assist greatly in delineating accurately the infected area and also may call attention to the spread of the disease to hitherto uninfected areas.

J. H. S. Gear.

Rickettsial and Virus Diseases Laboratory,
S.A. Institute for Medical Research,
P.O. Box 1038,
Johannesburg.
8 August 1951.

The Medical Association of South Africa
Die Mediese Vereniging van Suid-Afrika

AGENCY DEPARTMENT : AGENTSKAP AFDELING

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(724) Cape Town. Excellent opportunity for assistant in Northern suburbs. Salary and terms of engagement to be mutually arranged.

(744) Noordweste. Assistent vir algemene praktyk met klein private verpleeginrigting. £65 p.m. plus vry losies. Kar beskikbaar.

(781) Boland. Assistentskap vir vier maande. Salaris kan gereël word. Verkieslik maar nie noodwendig ongetroude assistent. Praktyk met D.S. en R.M.O. aanstellings.

(778) Noord-Kaapland. Hospitaaldorp. So spoedig moontlik vir een maand. £2 2s. p.d. plus inwoning en reiskoste. Kar word voorsien. Moontlikheid om aan te bly as assistent.

(779) Noord-Kaapland. Vir maand September. £2 12s. 6d. plus inwoning. 9d. per myl kar toelae.

(734) Eastern Province for three weeks from 14 September. £2 12s. 6d. p.d. Car allowance and board and lodging to be arranged.

(783) Namaqualand. From 1 September for six weeks on hospital staff. £3 3s. p.d. plus first-class return rail fare or equivalent cash plus board and lodging. Possibility permanent appointment with free unfurnished house.

(780) Transkei hospital town. For month December. £2 2s. p.d. plus hotel expenses. Car provided. Practice with D.S. appointment.

(776) Noord-Kaaplandse hospitaaldorp. Vir vier tot ses weke vanaf Desember of Januarie. £2 2s. per dag plus losies plus 9d. per myl kartoelae. Asook reiskoste gelykstaande aan eersteklas-retoerkaartjie.

ASSISTENTE/PLAASVERVANGERS BESKIKBAAR
ASSISTANTS/LOCUMS AVAILABLE

(755) For the month of September only, experienced gentile South African practitioner with own car available as locum in Eastern Province, preferably near King William's Town. Accommodation required for wife and two small children. Salary to be arranged. Working knowledge of Xosa.

(784) Lady doctor qualified Univ. C.T. 1944, additional experience Paediatrics, available as locum, assistant or Junior Partner.

(785) Geneesheer met ondervinding van algemene praktyk is vir November- en Desembermaand beskikbaar as assistent en/of plaasvervanger in die Skiereiland, Paarl of naburige dorpe. Salaris ens. kan gereël word.

MEDICAL EQUIPMENT FOR SALE

(758) Electrocardiograph. Sanborne Cardiette. Weight 24 lb. Perfect working condition. Used by Cape Town specialist physician. £160 or nearest offer.

(674) Complete up-to-date set of the British Encyclopaedia of Medical Practice. Any reasonable offer.

(772) (261) Teak desk, revolving chair, couch, instrument and dressing tables, cupboards and waiting room furniture, at £125. Instruments at £100. Microscope at £25.

SPREEKKAMERS : CONSULTING ROOMS

(761) Consulting room to let in centre of Cape Town. Waiting room and services to be shared.

* * * *

JOHANNESBURG

Medical House, 5 Esselen Street. Telephones 44-9134-5, 44-0817
Mediese Huis, Esselenstraat 5. Telefone 44-9134-5, 44-0817

PRAKTYKE TE KOOP : PRACTICES FOR SALE

(Pr S30) Johannesburg Partnership practice plus Solus practice. Mainly non-European. Present income £3,600 p.a. Premium for quick sale £1,250.

ASSISTENTE/PLAASVERVANGERS VERLANG
ASSISTANTS/LOCUMS REQUIRED

(L V112) Johannesburg from 18 December 1951 to 18 January 1952. £2 12s. 6d. p.d. plus all found and petrol and oil paid.

MEDICAL EQUIPMENT FOR SALE

(I 017) Leitz microscope £45.

(I 018) What offers? Complete set 'British Encyclopaedia of Medical Practice' plus all editions of 'Medical Progress' to 1950. Condition as new.

S.A. Medical Journal
S.A. Tydskrif vir Geneeskunde

The *Journal* is published weekly on Saturdays.

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All remittances, whether for subscriptions or advertisements, are payable to the Medical Association of South Africa, at the above address. Cheques should include exchange.

Author's reprints of papers can be obtained at cost. Order blanks will be forwarded to authors when page proofs are ready.

Transvaalse Provinsiale Administrasie

VAKATURES: BY PUBLIEKE HOSPITALE

Aansoeke word ingewag van kandidate met geskikte kwalifikasies vir die onderstaande poste by Transvaalse Publieke Hospitale.

Aansoeke moet gerig word aan die Superintendent van die betrokke hospitaal en moet volle besonderhede bevat aangaande die ouderdom, professionele, akademiese en taalkwalifikasies, ondervinding en huwelikstaat van die applikant en moet voorts 'n aanduiding bevat van die vroegste datum waarop diens aanvaar kan word.

Hospitaal	*Vakature*	*Salaris*	*Aanmerkings*
Johannesburg Hospitaalbestuur en die Universiteit van Witwatersrand			
Tara:	Registrateur in Neuropsigiatrie (1)	£620—780—820—860	Moet vir ten minste twee jaar gekwalifiseerd wees. Getroud plus (*a*) hieronder. Ongetroud plus (*b*) hieronder.
Vereeniging:	Mediese Registrateur (1)	£620—780—820—860	Getroud plus (*a*) hieronder. Ongetroud plus (*b*) hieronder

(*a*) £256 per jaar lewenskostetoelae.
(*b*) £80 per jaar lewenskostetoelae.

Van die persone wat aangestel word, sal verwag word om bevredigende sertifikate in te dien, asook om hulle te onderwerp aan 'n geneeskundige ondersoek by die betrokke hospitaal.

Aansoekvorms is verkrygbaar van die Provinsiale Sekretaris, Departement van Hospitaaldienste, Posbus 383, Pretoria.

Benewens jaarlikse salaris ontvang voltydse werknemers op die oomblik lewenskostetoelae, spoorwegkonsessie en word verlof toegestaan ooreenkomstig die hospitaal verlof-regulasies.

Die sluitingsdatum van aansoeke vir die poste is 4 September 1951.

(30452)

Natal Provincial Administration

VACANCIES: SENIOR MEDICAL OFFICERS: RADIOLOGY

Applications are invited from suitably experienced registered medical practitioners for appointment to the above-mentioned vacant posts at Government Hospitals in Durban.

Applicants for the posts are required to have at least two years' experience in approved Hospitals, and must undertake to serve the Administration for three years as Radiologists after receiving the Diploma in Medical Radiology.

The salary attaching to the post prior to qualification for the above-mentioned Diploma will be as follows:

(a) Two years' experience as a medical practitioner £400 per annum all found.

(b) Three years' experience as a medical practitioner £600 per annum plus free quarters or an allowance in lieu thereof.

(c) Four years' experience as a medical practitioner £700 per annum plus free quarters or an allowance in lieu thereof.

(d) Five years' experience as a medical practitioner £800 per annum plus free quarters or an allowance in lieu thereof.

After qualification for the Diploma in Medical Radiology, salary will be paid at the rate of £1,200 per annum for the first year, £1,500 per annum for the second year and £1,750 per annum for the third year.

Applications should be addressed to The Director of Provincial Medical and Health Services, P.O. Box 20, Pietermaritzburg, to reach him on or before 31 August 1951.

(AD 6456)

Anaesthetic Practice: Assistant

Assistant (with a view to a share in the partnership) required in an old-established anaesthetic practice in a coastal town. Write to "A. G. E.", P.O. Box 643, Cape Town.

National Industrial Council of the Leather Industry of South Africa

SICK BENEFIT FUND

Applications are invited from medical practitioners resident in the Pietermaritzburg District for appointment to a panel of part-time Medical Officers to the Fund to commence duties on 1 October 1951.

Full details as to conditions of appointment may be obtained from the Secretary, Sick Benefit Fund, National Industrial Council of the Leather Industry of South Africa, P.O. Box 3051, Port Elizabeth. Applications for appointment to the Fund should be similarly addressed and must be received not later than Monday, 3 September 1951.

KENNISGEWING

Departement van Gesondheid

VAKATURE VIR DEELTYDSE TANDAARTS BY DIE GESONDHEIDSENTRUM TE STELLENBOSCH

Die aandag word gevestig op 'n advertensie in die *Staatskoerant* van 3 Augustus 1951 waarby aansoeke om 'n vakante pos van deeltydse tandarts by die gesondheidsentrum te Stellenbosch gevra word.

Die suksesvolle kandidaat sal eenmaal per week drie uur lank beskikbaar moet wees en sal teen die tarief van £75 per jaar, alles ingesluit, besoldig word.

Daar moet aansoek gedoen word op die voorgeskrewe vorms Z. 83 en S.D.K. 8, wat van die Sekretaris van Gesondheid, Posbus 386, Pretoria, verkrygbaar is. (30235)

South African Railways and Harbours Sick Fund

APPOINTMENT OF RAILWAY MEDICAL OFFICER: GREYTOWN

Applications are invited from registered medical practitioners for the position of Railway Medical Officer, Greytown, and the sections Greytown to Dalton (excl.), to Mount Alida (incl.) and to Kranskop (incl.), at a salary of £273 per annum, plus the fees and allowances prescribed by the Regulations of the Sick Fund, and with the right of private practice.

The duties of the appointment will include the dispensing of the necessary medicine, which will be supplied by the Fund.

The salary will be subject to adjustment in accordance with the census of members to be taken on 1 April of each year.

The appointment will be made in terms of the Regulations of the Sick Fund, and will be subject to termination on four months' notice being given by either side.

The successful applicant will be required to reside in Greytown, to take up the appointment on a date to be arranged, and to carry out his duties in accordance with the Regulations of the Sick Fund.

Applications should reach the District Secretary, Natal District Sick Fund Board, Martin West Buildings, Smith Street, Durban, not later than 22 September 1951, and should state:—

1. Full name.
2. Qualifications (when and where obtained).
3. Experience (when and where obtained).
4. Date of birth.
5. Country of birth.
6. Whether married or single.
7. Whether fully bilingual.
8. Whether South African Citizen.
9. What Government appointment, if any, is held.

Canvassing by or on behalf of any applicant is liable to disqualify such applicant.

Any further particulars may be obtained from the District Secretary, at the above address, on application.

P. J. Klem
General Secretary

Johannesburg
25 August 1951 (4)

Village Board of Management of Allanridge

VACANCY

Applications are invited for the post of part-time medical officer of health at a remuneration of £60 per annum. Extent of duties and further particulars obtainable from the Secretary, P.O. Box 306, Odendaalsrus.

Applications close on 31 August 1951, at 3 p.m.

E. T. Rood
Secretary

Dorpsbestuur van Allanridge

VAKATURE

Aansoeke om 'n deeltydse mediese gesondheidsbeampte word ingewag teen 'n toelaag van £60 per jaar.

Omvang van dienste en besonderhede by die Sekretaris, Posbus 306, Odendaalsrus, verkrygbaar.

Applikasies sluit op 31 Augustus 1951, om 3 n.m.

E. T. Rood
Sekretaris

Doctor's Rooms

Surgery and waiting room, fully equipped, to share. London and Lancashire Building, St. George's Street, Cape Town. Write to 'A. H. W.', P.O. Box 643, Cape Town.

Municipality and Divisional Council of Paarl

VACANCY: MEDICAL OFFICER OF HEALTH (AMENDED NOTICE)

Applications are hereby invited from registered medical practitioners for the position of Medical Officer of Health. The post has been established jointly by the Municipality and the Divisional Council of Paarl, but for administrative purposes the encumbent will be subject to the conditions of service of the Municipality of Paarl. The salary attached to this post will be on the scale £1,500 × 50—£1,800 per annum plus the relevant temporary cost-of-living allowance which on the basis of the commencing salary is at present £109 4s. per annum for a single person and £256 per annum for a married person. The commencing salary will be determined according to the qualifications and experience of the successful candidate. Motor transport will be provided and the encumbent will be required to reside in the Municipal area of Paarl.

Applicants must be thoroughly bilingual and not more than 45 years of age and must be in possession of the Diploma in Public Health. The successful applicant will be required to submit a satisfactory certificate of good health, to serve a probationary period of six months and on confirmation of his appointment, will be required to join the Municipal Pension Fund. Experience in the medical treatment of Pulmonary Tuberculosis including artificial pneumothorax therapy is essential.

The successful candidate will be required to devote the whole of his time exclusively to the duties of Medical Officer of Health and will not be permitted to engage in private practice. He will be responsible to render within the districts of the Municipality and the Divisional Council of Paarl, all such clinical services and public health duties or any other services affecting the health or welfare of the community or any section thereof as may be required of him under any law or as may be lawfully required of him by the Municipality or the Divisional Council, including such services as the two local authorities concerned are required or authorized to perform under any relevant law in force from time to time. His duties will include the medical examination of employees and prospective employees of the Municipality and the Divisional Council, and food handlers operating in the district for which he is the Medical Officer of Health.

In addition to the venereal disease clinics and other clinics in the area of these two local authorities, he will conduct the medical treatment of the patients in the Council's V.D./T.B. hospital for non-Europeans which has 50 beds at present and will be the Medical Superintendent of this institution without additional remuneration.

The Medical Officer of Health will have charge of and be responsible for the proper control of the Health, Sanitation and Nursing Staff of the Municipality and the Divisional Council, and will be required to furnish the Government, the Muncipality and the Divisional Council with all necessary reports in writing, bearing on the functioning and administration of his Department.

Full particulars of qualifications and experience must be submitted with applications which must be lodged with the undersigned not later than 12 noon on the 31 August 1951.

C. H. Blignaut
Town Clerk

8 August 1951
(440)

Pilkington Brothers (S.A.) (Pty.) Limited

Applications are invited from medical practitioners resident in Springs for appointment as part-time Medical Officer to the above firm to commence duties as soon as possible.

Full information regarding the appointment may be obtained from the Secretary, P.O. Box 111, Springs.

Applications must be submitted before 1 September 1951.

Required

A full-time medical officer is required for the Native Medical Service of a West Rand Mine. Preference will be given to applicants who have had good medical and surgical experience. The commencing rate of salary is £110 per month plus cost-of-living allowance plus car allowance. Applicants should state age, marital status, and give details of experience together with any references they may have. The successful applicant is expected to commence duty on 1 October 1951. Applications must reach the Consulting Engineer, P.O. Box 7727, Johannesburg, not later than 31 August 1951.

Commodious Suite of 3 Consulting Rooms

In new Medical Centre, Durban North. Will suit two or three doctors having a common reception room. Immediate occupation and long lease at £18 p.m. Apply D. Caro & Company, 364 Smith Street. Telephone 2-5746.

Wanted

Male assistant with view to future partnership required for select busy European practice in Salisbury, Southern Rhodesia. Experience of general practice and thorough knowledge of current medicine essential. Must have own car. Write to 'A. H. V.', P.O. Box 643, Cape Town.

EMERGENCY MEDICAL SERVICE
(CAPE TOWN)

Why not join this service and let us take your calls, record them accurately and pass them on to you immediately.

Hours of Service

Weekdays: 5 p.m. to 9 a.m.

Week-ends: 1 p.m. Saturdays to 9 a.m. Mondays.

Holidays: From 5 p.m. on the evening preceding the holiday to 9 a.m. on the morning after the holiday.

Subscription: £2 2s. per month per subscriber, plus 12s. per annum, being charge for insertion of number in Telephone Directory.

For further particulars or extension of service, telephone 6-2997.

Note. The names of all those intending to join the Service must be received by 15 September, in order to have the numbers inserted in the new Telephone Directory.

Printed by Cape Times Ltd., Parow, and Published by the Proprietors, THE MEDICAL ASSOCIATION OF SOUTH AFRICA, MEDICAL HOUSE, 35 Wale Street, Cape Town. P.O. Box 643. Telephone 2-6177. Telegrams: 'Medical'

The concept that allergic tissue responses are important contributory factors in upper respiratory infections has been widely accepted. To combat these allergic manifestations more effectively, the time-tested, dependable decongestant—Neo-Synephrine hydrochloride—has been combined with a new, highly active antihistaminic—Thenfadil hydrochloride.

Neo-Synephrine® Thenfadil

HIGHLY EFFECTIVE DECONGESTANT ANTIHISTAMINIC

For symptomatic control of the common cold, allergic rhinitis including hay fever, vasomotor rhinitis and sinusitis.

Well Tolerated—No Drowsiness—Neo-Synephrine Thenfadil nasal solution in clinical tests was well tolerated except for a transitory stinging in a few cases. There was essential freedom from central nervous system stimulation: trepidation, restlessness, insomnia; neither was there drowsiness.

Effective—In common colds, allergic rhinitis including hay fever, vasomotor rhinitis, and sinusitis, excellent results were reported in nearly all cases. There was prompt, prolonged decongestion without compensatory vasodilatation. Repeated doses did not reduce the consistent effectiveness.

Dose: 2 or 3 drops up to ½ dropperful three or four times daily. Neo-Synephrine Thenfadil solution contains 0.25 per cent. Neo-Synephrine hydrochloride and 0.1 per cent. Thenfadil hydrochloride (N,N-dimethyl-N'-(3-chenyl)-N'-(2-pyridyl) ethylenediamine hydrochloride) in an isotonic buffered aqueous vehicle. Supplied in ¼% and 1% solutions in bottles of 30 c.c. (1 fl. oz.) with dropper.

Winthrop Products (Pty.) Ltd.

P.O. Box 2461 DURBAN
P.O. Box 9536 JOHANNESBURG
P.O. Box 4186 CAPE TOWN

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Thenfadil, trademark.

6064-2